Healthcare Audit and Enforcement Risk Analysis

HHS OIG Work Plan Summary Report Provider Focus

Active Work Plan Items

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To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year. In an effort to promote the value of shared learnings, as well as give our colleagues and clients organized summaries of the over 250 active HHS OIG Work Plan items, SunHawk Consulting, LLC, has gathered, organized, and summarized the HHS OIG Work Plan for the Payer and Provider Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The OIG Work Plan sets forth various projects, including OIG audits and evaluations, that are underway or planned to be addressed during the fiscal year and beyond. The Work Plan item summaries provided herein are referenced by their respective Work Plan numbers at the end of each abstract. SunHawk's report summarizes currently active Work Plan items and sorts relevant Work Plans items into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original Work Plan item summaries.

After your review, we would appreciate any feedback that would make this report more valuable to you or others. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to offertheir assistance. Visit us at SunHawkConsulting.com and connect with us on LinkedIn for updates on our Healthcare Audit and Enforcement Risk Analysis. SunHawk looks forward to working with you and your organization.

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

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Provider

Multiple Providers

Health Care Facilities and Geographic Areas With Potentially Limited Response Capabilities During the 2024 Hurricane Season

Expected Issue Date: 2025
Announced: August 2024

Hurricane season spans June 1 through November 30 each year, and the 2024 hurricane season was forecast to have above-normal storm activity. To strengthen preparedness and response capabilities—and ultimately improve continuity of care—OIG will synthesize program and performance data to provide new insights about health care facilities and geographic areas that may be at risk and potentially less prepared for a hurricane or similar storm event. This information could be used by HHS to minimize the potential effects of these risks before, during, or following a hurricane event.

Work Plan #: OEI-04-24-00390
Government Program: Office of Evaluation and Inspections

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

Expected Issue Date: 2026
Announced: June 2024

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

Work Plan #: OEI 09-24-00330
Government Program: Office of Evaluation and Inspections

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Provider

Audit of CARES Act Provider Relief Funds: General and Targeted Distributions to Providers

Expected Issue Date: 2025
Announced: October 2021

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act appropriated $178 billion for the Provider Relief Fund (PRF) to support health care providers affected by the COVID-19 pandemic. In April 2020, the Health Resources and Services Administration began distributing the funds through general distributions to Medicare providers based on 2018 net patient revenue and targeted distributions for certain provider types (e.g., providers in areas particularly impacted by COVID-19, skilled nursing providers, and providers in rural areas). Providers such as hospitals may be eligible for PRF payments from the general and targeted distributions. OIG will select for audit a judgemental sample of providers that received general and/or targeted distributions. OIG's objective is to determine whether providers that received PRF payments complied with certain Federal requirements, and the terms and conditions for reporting and expending PRF funds.

Work Plan #: W-00-20-35855
Government Program: Office of Audit Services

Audits of Medicare Payments for Spinal Pain Management Services

Expected Issue Date: Completed (partial)
Announced: May 2021

Medicare Part B covers various spinal pain management services including facet joint injections, facet joint denervation sessions, lumbar epidural injections, and trigger point injections. Medicare Part B also covers sedation administered during these pain management services. OIG will audit whether Medicare payments for spinal pain management services billed by physicians complied with Federal requirements.

Work Plan #: A-09-21-03002; SRS-A-25-006; A-09-20-03003; A-09-20-03010; A-09-22-03006; A-07-21-00618
Government Program: Office of Audit Services

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

Expected Issue Date: Completed
Announced: July 2020

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

determine whether they were eligible for AAP payments, and their efforts to repay CMS in compliance with the CARES Act and other Federal requirements.

Work Plan #: W-00-20-35854; A-05-20-00053; A-05-23-00005
Government Program: Office of Audit Services

Review of Post-Operative Services Provided in the Global Surgery Period

Expected Issue Date: 2025
Announced: July 2018

Section 523 of Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS to collect data on post-operative services included in global surgeries and requires OIG to audit and verify a sample of the data collected. OIG will review a sample of global surgeries to determine the number of post-operative services documented in the medical records and compare it to the number of post-operative services reported in the data collected by CMS. OIG will verify the accuracy of the number of post-operative visits reported to CMS by physicians and determine whether global surgery fees reflected the actual number of post-operative services that physicians provided to beneficiaries during the global surgery period.

Work Plan #: W-00-18-35810; W-00-22-35810
Government Program: Office of Audit Services

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Provider

Hospital

[NEW] Hospital Reporting of Patient Harm Events per CMS and State Requirements

Expected Issue Date: 2025
Announced: January 2025

Hospitals collect information about patient harm events to meet Medicare requirements to measure, analyze, and track adverse patient harm events. Hospitals are also required to report certain types of harm events to meet CMS program and State legal requirements. Prior OIG work found that hospitals reported few harm events to State reporting systems (Few Adverse Events in Hospitals Were Reported to State Adverse Event Reporting Systems (OEI-06-09-00092)). OIG will determine the extent to which hospitals reported harm events as required per CMS program and State requirements. OIG will use harm events identified through medical review for the study Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018 (OEI-06-18-00400) as the basis for this review. This is a supplemental product to OIG's ongoing study that is examining hospital identification of patient harm events (OEI-06-18-00401).

Work Plan #: OEI-06-18-00401
Government Program: Office of Evaluation and Inspections

Comparative Analysis Between Medicare Payments and Hospital's Published Prices

Expected Issue Date: 2026
Announced: September 2024

CMS issued a final rule (effective January 1, 2021), to improve transparency in health care costs by requiring hospitals to make their prices readily available for consumers (the Hospital Price Transparency (HPT) rule). CMS believes that the Hospital Price Transparency (HPT rule) will increase market competition and drive down the cost of health care services. One of the requirements of the HPT rule is for hospitals to make public all negotiated charges with third-party payers. OIG will examine and conduct an analysis to compare the pricing information published by the hospitals to the amounts that Medicare paid. Specifically, OIG will evaluate how much Medicare pays in comparison to the third-party payer negotiated charges and the minimum negotiated charges.

Work Plan #: OAS-24-07-001
Government Program: Office of Audit Services

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Medicare Enrollees Leaving Hospitals Against Medical Advice

Expected Issue Date: 2025
Announced: June 2024

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

Work Plan #: W-00-24-35915
Government Program: Office of Audit Services

Patient Safety Organizations: Key Insights, Challenges, and Opportunities

Expected Issue Date: 2025
Announced: March 2024

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

Work Plan #: OEI-01-24-00150
Government Program: Office of Evaluation and Inspections

Medicare Inpatient Hospital Billing for Sepsis

Expected Issue Date: 2025
Announced: March 2024

Sepsis is the body's extreme response to an infection. It is a life-threatening, emergency medical issue that often progresses quickly and responds best to early intervention. The definition of and guidance for sepsis have changed over the years in attempts to identify it more accurately. The definition of sepsis was updated in 2016 by an international task

force to better differentiate sepsis from a general infection. This narrower definition is widely recognized by groups such as the World Health Organization. However, CMS and CDC currently recognize an older, broader definition. Sepsis is a frequently billed diagnosis in Medicare. There are concerns that hospitals may be taking advantage of this broader definition, as they have a financial incentive to do so. This study will analyze Medicare claims to assess patterns in the inpatient hospital billing of sepsis in 2023 and describe how the billing of sepsis varied among hospitals. OIG will also estimate the costs to Medicare associated with using the broader, rather than the narrower, definition of sepsis.

Work Plan #: OEI-02-24-00230
Government Program: Office of Evaluation and Inspections

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

Expected Issue Date: 2025
Announced: December 2023

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

Work Plan #: WA-23-0041 (W-00-23-35904)
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: July 2023

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

Work Plan #: OEI-01-23-00290
Government Program: Office of Evaluation and Inspections

Hospital Identification of Patient Harm Events

Expected Issue Date: 2025
Announced: May 2023

Hospitals collect information about patient harm events to meet Medicare requirements to measure, analyze, and track adverse patient harm events. Incident reporting systems enable providers and hospital staff to report information about patient safety incidents when they occur. In addition to general incident reporting systems, hospitals use other surveillance systems to capture events within specific hospital departments, such as the hospital pharmacy, or to capture specific types of adverse events, such as infections. Hospitals analyze this information to identify trends and root causes of safety issues to improve care and prevent recurrences of harm events. OIG will determine the extent to which hospitals identify patient harm events and report those events to external entities. OIG will use harm events OIG identified through medical review for the study Adverse Events in Hospitals: A Quarter of Medicare Patients Experienced Harm in October 2018 (OEI-06-18-00400) as the basis for this review.

Work Plan #: OEI-06-18-00401
Government Program: Office of Evaluation and Inspections

Review of Medicare Payments for Trauma Claims

Expected Issue Date: 2025
Announced: November 2022

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

Work Plan #: WA-23-0004 (W-00-23-35893)
Government Program: Office of Audit Services

Inpatient Rehabilitation Facility Nationwide Audit

Expected Issue Date: 2024
Announced: September 2022

Inpatient rehabilitation facilities (IRFs) provide intensive inpatient rehabilitation therapy for patients who have complex nursing, medical management, and rehabilitation needs that require hospital-level treatment in an inpatient environment. In fiscal year 2021, Medicare paid approximately $8.7 billion for 373,000 IRF stays nationwide. The Centers for Medicare

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& Medicaid Services (CMS) has consistently found high IRF error rates through its Comprehensive Error Rate Testing program. For an IRF claim to be considered reasonable and necessary, it must meet certain coverage and documentation requirements. OIG issued a nationwide audit of IRF claims in September 2018, Many Inpatient Rehabilitation Facility Stays Did Not Meet Medicare Coverage and Documentation Requirements (A-01-15-00500), that found that medical record documentation for 175 of 220 sampled IRF stays did not support that the IRF care was reasonable and necessary in accordance with Medicare requirements. OIG's Hospital Compliance audits also frequently include IRF claims and have similarly found high error rates. In response to these findings, IRF stakeholders have stated that Medicare audit contractors and OIG have misconstrued the IRF coverage regulations. To better understand which claims IRFs believe are properly payable by Medicare, OIG needs more information from the IRF stakeholders. OIG plans to determine whether there are areas in which CMS can clarify Medicare IRF claims payment criteria. In addition, OIG will follow up on recommendations from the prior IRF audit, A-01-15-00500. OIG believes data and input from IRF stakeholders are critical to identifying any specific areas that might require clarification and will result in more meaningful recommendations and a greater positive impact on the program. This audit will be an independent performance audit in accordance with Generally Accepted Government Auditing Standards.

Work Plan #: WA-22-0014 (W-00-22-35891)
Government Program: Office of Audit Services

Hospital Price Transparency

Expected Issue Date: 2025
Announced: September 2022

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

Work Plan #: WA-22-0013 (W-00-22-35890)
Government Program: Office of Audit Services

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

Expected Issue Date: Completed
Announced: May 2022

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

Work Plan #: A-09-23-03016
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: January 2022

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

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balance billing requirement.

Work Plan #: W-00-22-35878
Government Program: Office of Audit Services

Medicaid Inpatient Hospital Claims With Severe Malnutrition

Expected Issue Date: 2025
Announced: November 2021

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

Work Plan #: W-00-22-31558
Government Program: Office of Audit Services

Medicare Payments for Inpatient Claims With Mechanical Ventilation

Expected Issue Date: Completed
Announced: November 2021

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

Work Plan #: A-09-22-03002
Government Program: Office of Audit Services

Audit of Medicare Emergency Department Evaluation and Management Services

Expected Issue Date: 2025
Announced: August 2021

An emergency department is defined as an organized, hospital-based facility for providing unscheduled or episodic services to patients who present for immediate medical attention. Certain Current Procedural Terminology (CPT) codes should only be used when a beneficiary is seen in an emergency department and the services described by the health care CPT coding system code definition are provided. Medicare reimburses physicians based on a patient's documented

needs at the time of a visit. All evaluation and management (E/M) services reported to Medicare must be adequately documented so that medical necessity is clearly evident. This review will determine whether Medicare payments to providers for emergency department E/M services were appropriate, medically necessary, and paid in accordance with Medicare requirements.

Work Plan #: W-00-21-35877; W-00-22-35877
Government Program: Office of Audit Services

CMS Oversight of the Two-Midnight Rule for Inpatient Admissions

Expected Issue Date: 2025
Announced: November 2020

Prior OIG audits identified millions of dollars in overpayments for inpatient claims with short lengths of stay. Instead of billing the stays as inpatient claims, they should have been billed as outpatient claims, which usually results in a lower payment. To reduce inpatient admission errors, CMS implemented the Two-Midnight Rule in fiscal year 2014. Under the Two-Midnight Rule, CMS generally considered it inappropriate to receive payment under the inpatient prospective payment system for stays not expected to span at least two midnights. The only procedures excluded from the rule were newly initiated mechanical ventilation and any procedures appearing on the Inpatient Only List. Revisions were made to the Two-Midnight Rule after its implementation. OIG plans to audit hospital inpatient claims after the implementation of and revisions to the Two-Midnight Rule to determine whether inpatient claims with short lengths of stay were incorrectly billed as inpatient and should have been billed as outpatient or outpatient with observation. OIG also plans to review policies and procedures for enforcing the Two-Midnight Rule at the administrative level and contractor level. While OIG previously stated that it would not audit short stays after October 1, 2013, this serves as notification that OIG will begin auditing short stay claims again, and when appropriate, recommend overpayment collections.

Work Plan #: W-00-20-35857; A-09-21-03022
Government Program: Office of Audit Services

Swing-Bed Services at Nationwide Critical Access Hospitals

Expected Issue Date: 2025
Announced: August 2020

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

Work Plan #: W-00-20-35853
Government Program: Office of Audit Services

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

Expected Issue Date: Completed (partial)
Announced: April 2020

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

Work Plan #: A-02-21-01003; W-00-20-35845; W-00-21-35845
Government Program: Office of Audit Services

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

Expected Issue Date: 2024
Announced: March 2020

Medicare's acute- and post-acute-care transfer policies designate some discharges as transfers when beneficiaries receive care from certain post-acute-care facilities. The diagnosis-related group (DRG) payment provides payment in full to hospitals for all inpatient services associated with a particular diagnosis. Because of its transfer payment policies, Medicare pays hospitals a per diem rate for early discharges when beneficiaries are transferred to another prospective payment system hospital or to post-acute-care settings, including skilled nursing facilities, inpatient rehabilitation facilities, home health agencies, long-term-care hospitals, psychiatric hospitals, and hospice. This is based on the presumption that hospitals should not receive full payments for beneficiaries discharged early and then admitted for additional care in other clinical settings. Previous Office of Inspector General reviews identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy. OIG will review Medicare hospital discharges that were paid a full DRG payment when the patient was transferred to a facility covered by the acute and post-acute transfer policies where Medicaid paid for the service. Under the acute- and post-acute transfer policies, these hospital inpatient stays should have been paid a reduced amount. Additionally, OIG will assess the transfer policies to determine if they are adequately preventing cost shifting across healthcare settings.

Work Plan #: W-00-20-35832
Government Program: Office of Audit Services

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

Expected Issue Date: Completed
Announced: January 2019

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

Work Plan #: A-07-19-00560
Government Program: Office of Audit Services

Selected Inpatient and Outpatient Billing Requirements

Expected Issue Date: Completed (partial)
Announced: October 2017

This review is part of a series of hospital compliance reviews that focus on hospitals with claims that may be at risk for overpayments. Prior OIG reviews and investigations have identified areas at risk for noncompliance with Medicare billing requirements. OIG will review Medicare payments to acute care hospitals to determine hospitals' compliance with selected billing requirements and recommend recovery of overpayments. The review will focus on those hospitals with claims that may be at risk for overpayments. W-00-17-35538

Work Plan #: A-04-17-08057; A-04-17-08055; A-01-15-00515; A-05-16-00064; A-04-16-04049; A-05-16-00062; A-05-17-00026; A-07-17-05102; A-02-18-01018; A-02-18-01025; A-05-19-00024; A-02-20-01004; A-04-21-08084; W-00-20-35538; W-00-17-35538; W-00-23-35538; various reviews
Government Program: Office of Audit Services

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Provider

Long Term Care

Medicaid Nursing Facility Supplemental Payments

Expected Issue Date: 2025
Announced: April 2024

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

Work Plan #: WA-24-0038 (W-00-24-31579)
Government Program: Office of Audit Services

Audit of Nursing Facility Drug Overdoses

Expected Issue Date: 2025
Announced: March 2024

Drug abuse and overdose deaths are at epidemic levels in the United States. According to the Centers for Disease Control and Prevention, more than 1 million Americans died from an overdose during 1999-2021, with 80,000 of those deaths occurring in 2021. People who have had at least one overdose are more likely to have another. For every drug overdose that results in death, there are many more nonfatal overdoses, each one with its own emotional and economic toll. OIG will determine whether selected nursing facilities complied with quality-of-care requirements and reported, investigated, and implemented corrective actions for potential illegal drug usage and significant pain medication errors involving opioid overdoses.

Work Plan #: WA-24-0030 (W-00-24-31578)
Government Program: Office of Audit Services

Assessing the Accuracy of Nursing Home Falls Reporting in MDS Assessments

Expected Issue Date: 2025
Announced: March 2024

In the Medicare and Medicaid programs, when a nursing home resident experiences a fall, the nursing home is required to report that fall, and the severity of any resulting injury, in a patient assessment. CMS then uses this information to determine, for each Medicare-certified nursing home, the percentage of residents experiencing falls resulting in major injury. This percentage is posted on CMS's Care Compare website to give consumers information about the relative performance of each nursing home. In this study, OIG will assess the accuracy of the patient assessment data used to

calculate nursing home falls rates. Specifically, OIG will identify hospitalizations due to falls with major injury among Medicare enrollees receiving nursing home care using Medicare claims. In the first study, OIG will assess the extent to which those falls were reported by nursing homes in patient assessments. OIG will examine the characteristics of the people who did not have their falls reported. Finally, OIG will examine the characteristics of nursing homes that did not report falls among their residents. In the second product, OIG will provide additional details about the falls with major injury and hospitalization that OIG identifies, which could include the amount of time spent in the hospital, the cost of the hospital stays to the Medicare program and enrollees, and outcomes.

Work Plan #: OEI-05-24-00180; OEI-05-24-00181
Government Program: Office of Evaluation and Inspections

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

Expected Issue Date: 2025
Announced: January 2024

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

Work Plan #: WA-24-0026 (W-00-24-35909)
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: January 2024

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

Work Plan #: WA-24-0024 (W-00-24-31576)
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: November 2023

Nursing homes are required to electronically submit complete and accurate direct care staffing information to CMS's Payroll-Based Journal (PBJ) system on a quarterly basis. Direct care staff include nurse and non-nurse staff who, through interpersonal contact with nursing home residents or resident care management, provide care and services to residents to allow them to attain or maintain the highest practicable physical, mental, and psychosocial well-being. CMS and other stakeholders use the staffing information in the PBJ to: (1) measure nursing home performance, (2) better understand the relationship between nursing home staffing levels and the quality of care that nursing homes provide, (3) identify noncompliance with Federal nurse staffing regulations, and (4) facilitate the development of nursing home staffing measures. OIG will review the nurse staffing hours reported in the PBJ to determine whether the reported hours are accurate.

Work Plan #: WA-24-0011 (W-00-24-31575)
Government Program: Office of Audit Services

Audit of Nursing Homes' Emergency Power Systems

Expected Issue Date: 2025
Announced: July 2023

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

Work Plan #: WA-23-0026 (W-00-23-31571)
Government Program: Office of Audit Services

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State Survey Agency Processes for Overseeing Nursing Home Preparedness

Expected Issue Date: 2025OEI-02-23-00300
Announced: March 2023

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

Work Plan #: OEI-04-23-00030
Government Program: Office of Evaluation and Inspections

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

Expected Issue Date: 2025
Announced: February 2023

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

Work Plan #: OEI-02-23-00200; OEI-02-23-00201
Government Program: Office of Evaluation and Inspections

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

Expected Issue Date: 2025
Announced: January 2023

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

Work Plan #: OEI-04-22-00550
Government Program: Office of Evaluation and Inspections

Assessment of the Special Focus Facility Program for Nursing Homes

Expected Issue Date: 2025
Announced: January 2023

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

Work Plan #: OEI-01-23-00050; OEI-01-23-00052
Government Program: Office of Evaluation and Inspections

Audit of Medicaid Nursing Facility Use of Funds Related to Direct Patient Care

Expected Issue Date: 2025
Announced: November 2022

Improving safety, quality, and transparency of Medicaid nursing facility care is a top priority to ensure that seniors, people with disabilities, and others living in nursing homes receive reliable, high-quality care. States have broad flexibility when establishing Medicaid base and supplemental payments to provide adequate, performance-driven nursing facility rates. OIG will judgmentally select three facilities in selected States (one each from the following facility types: for-profit,

not-for-profit, and governmental) to determine what percentage of Medicaid nursing facility revenue is being expended on direct patient care.

Work Plan #: WA-23-0003 (W-00-23-31568)
Government Program: Office of Audit Services

States' Oversight of Residential Facilities To Protect Children From Maltreatment

Expected Issue Date: Completed
Announced: November 2022

States monitor and license federally funded residential facilities for children, but policymakers and the media have reported on incidents of child abuse and neglect (collectively referred to as maltreatment) that raise concerns about the effectiveness of States' oversight efforts to protect children in these settings. OIG will interview State child welfare and licensing agencies to assess how they monitor and address reports of maltreatment in child residential facilities. Identification of gaps in State oversight of residential facilities for children and potential promising practices (e.g., innovative policies or activities that could help address maltreatment) could help the Administration for Children and Families and States improve their oversight and better protect the children placed in these facilities.

Work Plan #: OEI-07-22-00530
Government Program: Office of Evaluation and Inspections

COVID-19 Pandemic Relief Funding and Its Effects on Nursing Homes in Select Locations: Pandemic Response Accountability Committee Impact Study

Expected Issue Date: Completed (partial)
Announced: October 2022

The Pandemic Response Accountability Committee (PRAC) is producing a report about COVID-19 pandemic relief funding in six communities selected by PRAC for review. As part of PRAC's efforts, OIG will review Provider Relief Fund (PRF) payments and their effects on nursing homes in the selected locations. Congress and HHS have used the PRF to support nursing homes and other health care providers during the pandemic. HHS allocated $9.5 billion from the PRF directly to nursing homes through two channels: (1) a distribution to skilled nursing facilities for lost revenue and expenses related to preventing, preparing for, and responding to COVID-19; and (2) the Nursing Home Infection Control Distribution for improving infection control practices and reducing rates of COVID-19 infection. In addition to contributing to PRAC's report for the five locations with nursing homes that received PRF payments, OIG will use interviews and other data collected as part of those efforts to produce its own evaluation of nursing home use of PRF payments and Health Resources and Services Administration oversight.

Work Plan #: OEI-06-22-00040; OEI-06-22-00440; OEI-06-22-00450; OEI-06-22-00460; OEI-06-22-00470; OEI-06-22-00480
Government Program: Office of Evaluation and Inspections

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Potentially Preventable Hospitalizations of Medicare-Eligible Skilled Nursing Facility Residents

Expected Issue Date: 2024
Announced: October 2022

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

Work Plan #: WA-23-0002 (W-00-23-35892)
Government Program: Office of Audit Services

Skilled Nursing Facilities' Medicare Payments to Related Parties

Expected Issue Date: 2025
Announced: August 2022

Understanding skilled nursing facilities' (SNFs') costs is crucial to understanding the factors that contribute to nursing home performance and how nursing homes deliver care to beneficiaries. The cost of services, facilities, and supplies furnished to a provider by an organization related to the provider by common ownership or control may be included in the allowable cost of the provider in an amount equal to the related organization's cost. However, such cost must not exceed the price of comparable services, facilities, and supplies that could be purchased elsewhere. Medicare requires that a reported amount be the lower of either the actual cost to the related organization or the market price for comparable services, facilities, or supplies, thereby removing any incentive to realize profits through these transactions. OIG will determine whether SNFs are reporting related-party costs in accordance with Federal regulations. OIG will also determine whether a SNF's allocation of Medicare funds could impact beneficiary care, such as whether overhead costs might have increased while allocations for patient care decreased, potentially reducing care.

Work Plan #: WA-22-0004 (W-00-22-35887)
Government Program: Office of Audit Services

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Background Checks for Nursing Home Employees

Expected Issue Date: Completed (partial)
Announced: January 2021

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

Work Plan #: W-00-21-31553; A-06-21-02000; A-04-23-08100
Government Program: Office of Audit Services

Audit of Nursing Home Infection Prevention and Control Program Deficiencies

Expected Issue Date: Completed (Partial)
Announced: May 2020

The Centers for Disease Control and Prevention has indicated that individuals at high risk for severe illness from coronavirus disease 2019 (COVID-19) are people aged 65 years and older and those who live in a nursing home. Currently, more than 1.3 million residents live in approximately 15,450 Medicare- and Medicaid-certified nursing homes in the United States. As of February 2020, State Survey Agencies have cited more than 6,600 of these nursing homes (nearly 43 percent) for infection prevention and control program deficiencies, including lack of a correction plan in place for these deficiencies. To reduce the likelihood of contracting and spreading COVID-19 at these nursing homes, effective internal controls must be in place. OIG's objective is to determine whether selected nursing homes have programs for infection prevention and control and emergency preparedness in accordance with Federal requirements.

Work Plan #: W-00-20-31545; A-01-20-00005; A-01-20-00004; A-01-22-00001
Government Program: Office of Audit Services

Medicaid Nursing Home Life Safety and Emergency Preparedness Reviews

Expected Issue Date: Completed
Announced: March 2020

Previous OIG audits on Medicaid nursing home life safety and emergency preparedness have identified multiple issues that put vulnerable populations at risk and indicated that nursing homes in various States are not complying with these requirements. In 2016, CMS updated its health care facilities' life safety and emergency preparedness requirements to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term-care (LTC) facilities. In addition, in 2019 CMS also issued expanded guidance on emerging infectious disease control to ensure that health care facilities are prepared to respond to threats from infectious diseases. OIG is reviewing this area because

residents of LTC facilities are particularly vulnerable to risks such as fires, natural disasters, or disease outbreak (such as COVID-19 and other coronaviruses). OIG's objective is to determine whether LTC facilities that received Medicare or Medicaid funds complied with new Federal requirements for life safety and emergency and infectious disease control preparedness.

Work Plan #: W-00-20-31525; W-00-22-31525:W-00-23-31525; A-02-21-01010; A-04-22-08093; A-09-22-02006; A-03-22-00206; A-06-22-09007; A-07-22-07009; A-01-23-00003
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: August 2019

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

Work Plan #: W-00-19-35824; W-00-22-35824
Government Program: Office of Audit Services

Skilled Nursing Facility Reimbursement

Expected Issue Date: 2024
Announced: November 2016

A skilled nursing facility (SNF) is a nursing home that provides skilled nursing care and rehabilitation services such as physical, speech, and occupational therapy to beneficiaries who need assistance after hospitalization. In October 2019, the Centers for Medicare & Medicaid Services (CMS) implemented a new payment system for determining Medicare Part A payments to SNFs. Specifically, CMS implemented the Patient Driven Payment Model (PDPM), a new case-mix classification system for classifying SNF patients in a Medicare Part A covered stay into payments groups under the SNF Prospective Payment System. Under PDPM, payment is determined by factoring in a combination of six payment components. Five of the components are case-mix adjusted and include a physical therapy component, an occupational therapy component, a speech-language pathology component, a nontherapy ancillary services component, and a nursing component. Additionally, there is a non-case-mix adjusted component to cover utilization of SNF resources that do not vary according to patient characteristics. OIG will determine whether Medicare payments to SNFs under PDPM complied with Medicare requirements.

Work Plan #: W-00-21-35784
Government Program: Office of Audit Services

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Medicare Payments for Home Dialysis Services

Expected Issue Date: 2025
Announced: December 2023

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

Work Plan #: WA-24-0016 (W-00-24-35908)
Government Program: Office of Audit Services

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

Expected Issue Date: Completed (partial)
Announced: October 2021

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

Work Plan #: W-00-20-31543; W-00-21-31543; A-07-21-03247
Government Program: Office of Audit Services

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Medicaid Personal Care Services

Expected Issue Date: Completed (partial)
Announced: April 2019

Personal care services (PCS) is a Medicaid benefit for the elderly, people with disabilities, and people with chronic or temporary conditions. It assists them with activities of daily living and helps them remain in their homes and communities. Examples of PCS include bathing, dressing, light housework, money management, meal preparation, and transportation. Prior OIG reviews identified significant problems with States' compliance with PCS requirements. Some reviews also showed that program safeguards intended to ensure medical necessity, patient safety, and quality, and prevent improper payments were often ineffective. OIG will determine whether improvements have been made to the oversight and monitoring of PCS and whether those improvements have reduced the number of PCS claims not in compliance with Federal and State requirements.

Work Plan #: A-02-19-01016; W-00-19-31536
Government Program: Office of Audit Services

Home Health Compliance with Medicare Requirements

Expected Issue Date: Completed (partial)
Announced: October 2017

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

Work Plan #: A-06-16-05005; A-02-17-01025; A-02-16-01001; A-05-16-00057; A-05-16-00055; A-01-16-00500; A-07-16-05092; A-07-16-05093; A-05-17-00022; A-02-17-01022; A-03-17-00004; A-04-16-06195; A-03-17-00009; A-02-19-01013; W-00-19-35712; W-00-16-35712; W-00-16-35501; W-00-17-35712; various reviews
Government Program: Office of Audit Services

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Consumer-Directed Personal Assistance Program

Expected Issue Date: Completed (partial)
Announced: July 2017

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

Work Plan #: A-02-16-01026; W-00-16-31035; W-00-20-31035; A-07-20-03243
Government Program: Office of Audit Services

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Hospice

Audit of Medicaid's Hospice Inpatient and Aggregate Cap Calculations

Expected Issue Date: 2025
Announced: January 2024

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

Work Plan #: WA-24-0025 (W-00-24-31577)
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: June 2023

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

Work Plan #: WA-23-0020 (W-00-23-35897)
Government Program: Office of Audit Services

Nationwide Review of Hospice Beneficiary Eligibility

Expected Issue Date: 2024
Announced: January 2022

Hospice care can provide comfort to beneficiaries, families, and caregivers at the end of beneficiaries' lives. To be eligible for hospice care, they must be entitled to Medicare Part A and be certified as being terminally ill. The certification of terminal illness for hospice benefits shall be based on the clinical judgment of the hospice medical director or physician member of the interdisciplinary group, and the beneficiaries' attending physician, if they have one, regarding

the normal course of their illness. OAS has performed several compliance audits of individual hospice providers in recent years, and each of those audit reports identified findings related to beneficiary eligibility. OIG will perform a nationwide review of hospice eligibility, focusing on those hospice beneficiaries that haven't had an inpatient hospital stay or an emergency room visit in certain periods prior to their start of hospice care.

Work Plan #: W-00-22-35883
Government Program: Office of Audit Services

Review of Hospice Inpatient and Aggregate Cap Calculations

Expected Issue Date: Completed (partial)
Announced: October 2019

Hospice care can provide great comfort to beneficiaries, families, and caregivers at the end of a beneficiary's life. To ensure that hospice care does not exceed the cost of conventional medical care at the end of life, Medicare imposes two annual limits to payments made to hospice providers: the inpatient cap and the aggregate cap. The inpatient cap limits the number of days of inpatient care for which Medicare will pay to 20 percent of a hospice's total Medicare patient care days, and a hospice must refund to Medicare any payment amounts in excess of the inpatient cap. The aggregate cap limits the total aggregate payments that any individual hospice can receive in a cap year to an allowable amount based on an annual per-beneficiary cap amount and the number of beneficiaries served. Any amount paid to a hospice for its claims in excess of the aggregate cap is considered an overpayment and must be repaid to Medicare. Medicare administrative contractors (MACs) oversee the cap process and hospices must file their self-determined aggregate cap determination notice with their MAC no later than 5 months after the end of the cap year and remit any overpayment due at that time.

Work Plan #: W-00-19-35826; W-00-21-35826; A-06-21-08004
Government Program: Office of Audit Services

Medicare Payments Made Outside of the Hospice Benefit

Expected Issue Date: Completed (partial)
Announced: June 2018

According to 42 CFR 418.24(d), in general, a hospice beneficiary waives all rights to Medicare payments for any services that are related to the treatment of the terminal condition for which hospice care was elected. The hospice agency assumes responsibility for medical care related to the beneficiary's terminal illness and related conditions. Medicare continues to pay for covered medical services that are not related to the terminal illness. Prior OIG reviews have identified separate payments that should have been covered under the per diem payments made to hospice organizations. OIG will produce summary data on all Medicare payments made outside the hospice benefit, without determining the appropriateness of such payments, for beneficiaries who are under hospice care. In addition, OIG will conduct separate reviews of selected individual categories of services (e.g., durable medical equipment, prosthetics, orthotics and supplies, physician services, outpatient) to determine whether payments made outside of the hospice benefit complied with Federal requirements.

Work Plan #: W-00-20-35797; A-09-20-03026; A-09-20-03015
Government Program: Office of Audit Services

Review of Hospices' Compliance with Medicare Requirements

Expected Issue Date: Completed (partial)
Announced: November 2016

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

Work Plan #: A-02-16-01023; A-02-16-01024; A-02-18-01001; A-09-18-03016; A-09-18-03017; A-09-18-03028; A-09-20-03034; A-09-20-03035; A-09-18-03024; A-09-18-03009; W-00-16-35783; W-00-18-35783; various reviews; A-02-19-01018; A-02-20-01001
Government Program: Office of Audit Services

SUNHAWK CONSULTING

Provider

Medical Equipment and Supplies

CMS's Use of Surety Bonds To Protect Medicare Part B From Overpayments to Durable Medical Equipment Suppliers

Expected Issue Date: 2026
Announced: February 2025

To limit the financial risk that fraudulent suppliers of durable medical equipment (DME) pose to Medicare, CMS implemented a surety bond requirement in 2009 that held promise as a tool to: (1) deter fraud and (2) recover overpayments. For over a decade, OIG has raised concerns about fraudulent practices among DME suppliers and has highlighted billions of dollars in potentially improper Medicare payments made to suppliers. In 2013, OIG reported that CMS underutilized surety bonds as a tool to protect Medicare from overpayments to DME suppliers. CMS recovered only $263,000 from surety bonds of $50 million in overpayments identified for collection between October 2009 and April 2011. This evaluation will update and expand upon this work. OIG plans to determine: (1) the total amount of outstanding DME overpayments that became eligible for surety bond collection in CY 2023, (2) the total amount of outstanding DME overpayments that have been collected and left uncollected from surety bonds, (3) potential obstacles DME Medicare Administrative Contractors and CMS face in collecting outstanding DME overpayments from surety bonds, and (4) potential changes that could make surety bonds a more effective tool to deter fraud and recover DME overpayments.

Work Plan #: OEI-03-25-00080
Government Program: Office of Evaluation and Inspections

Wheelchair Repair Services for Medicare Enrollees

Expected Issue Date: 2026
Announced: October 2024

Wheelchair malfunctions and subsequent repairs are disruptive to users' mobility, and media sources have raised concerns about the timeliness and quality of wheelchair repair services. Wheelchair suppliers must adhere to quality standards set by legislation and by CMS. This evaluation will examine durable medical equipment suppliers who provide wheelchair repair services and will consider the duration of repairs, suppliers' implementation of selected quality standards, and accreditors' identification of deficiencies related to wheelchair repairs. OIG will review documentation from wheelchair suppliers and accreditation organizations and conduct interviews with CMS, accreditation organizations, and Medicare enrollees.

Work Plan #: OEI-07-24-00380
Government Program: Office of Evaluation and Inspections

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Physical and Other Therapies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

Medicare Payments to Suppliers for Oxygen and Oxygen Equipment

Expected Issue Date: 2026
Announced: October 2024

Medicare covers reasonable and necessary durable medical equipment, prosthetics, and orthotics supplies, such as oxygen and oxygen equipment (Social Security Act §§ 1861(n), (s)(6), (8), and (9) and § 1862 (a)(1)(A)). For calendar year 2023, Medicare paid more than $674 million for oxygen and oxygen equipment. CMS has consistently identified high rates of improper payment for oxygen and oxygen equipment through its Comprehensive Error Rate Testing program. Upon request, a supplier must provide documentation, including records from the treating practitioner, indicating that oxygen and oxygen equipment were reasonable and necessary for an enrollee's condition (42 CFR § 410.38(d)(3)). OIG will determine whether Medicare paid suppliers for oxygen and oxygen equipment according to Medicare requirements.

Work Plan #: OAS-24-09-012
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: July 2024

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

Work Plan #: WA-24-0059 (W-00-24-35919)
Government Program: Office of Audit Services

Durable Medical Equipment Fraud and Safeguards in Medicare

Expected Issue Date: 2025
Announced: June 2024

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

Work Plan #: OEI-02-24-00310
Government Program: Office of Evaluation and Inspections

Medicare Payments Compared to the Prices Available to Consumers and Suppliers for Continuous Glucose Monitors and Sensors

Expected Issue Date: 2025
Announced: November 2023

OIG will compare Medicare payments to suppliers' acquisition costs and prices otherwise available to consumers for selected continuous glucose monitors (CGMs) and their sensors to determine if there are potential cost savings for Medicare and enrollees. In 2022, Medicare Part B allowed more than $1.1 billion in payments for CGMs and sensors. If OIG finds that Medicare payments for CGMs greatly exceed their acquisition costs, then CMS has authority to adjust payment rates for CGMs and sensors through two methods: CMS can adjust the fee schedule prices using its inherent reasonableness authority, or it can introduce an item into the Medicare Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Competitive Bidding Program.

Work Plan #: OEI-04-23-00430
Government Program: Office of Evaluation and Inspections

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

Expected Issue Date: 2025
Announced: September 2023

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

subparagraph 42 U.S.C. § 1395w-3(a)(1)(E)). OIG will review the process used by CMS to conduct competitive bidding and to make subsequent pricing determinations during round 2021 of the competitive bidding program.

Work Plan #: WA-23-0033 (W-00-23-35901)
Government Program: Office of Audit Services

Medicare Payments for Intermittent Urinary Catheters

Expected Issue Date: 2025
Announced: July 2022

Medicare covers reasonable and necessary durable medical equipment, prosthetics, and orthotics supplies (DMEPOS), such as intermittent urinary catheters (Social Security Act § 1861 (n) and (s)(8), and 1862(a)(1)(A)). For calendar year 2021, Medicare paid more than $308 million for intermittent urinary catheters. Prior reviews performed by OIG and CMS contractors have identified high improper payment rates for urological supplies (including intermittent urinary catheters) that did not meet Medicare requirements. Upon request, a supplier must provide documentation from the physician or treating practitioner indicating that the urological supplies were reasonable and necessary for the beneficiary's condition (42 CFR § 410.38(d)(3)). OIG will audit Medicare payments for intermittent urinary catheters to determine whether claims submitted by DMEPOS suppliers complied with Medicare requirements and guidance.

Work Plan #: WA-22-0008 (W-00-22-35888)
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: January 2021

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

Work Plan #: W-00-21-35863
Government Program: Office of Audit Services

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Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Physical and Other Therapies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

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

Expected Issue Date: 2024
Announced: August 2019

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

Work Plan #: W-00-19-35823; W-00-22-35823
Government Program: Office of Audit Services

Competitive Bidding for Medical Equipment Items and Services - Mandatory Review

Expected Issue Date: Completed (partial)
Announced: October 2017

Federal law requires OIG to conduct postaward audits to assess Centers for Medicare & Medicaid Services's competitive bidding program. (Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), § 154(a)(1)(E)). OIG will review the process Centers for Medicare & Medicaid Services used to conduct competitive bidding and to make subsequent pricing determinations for certain medical equipment items and services in selected competitive bidding areas under rounds 1 and 2 of the competitive bidding program.

Work Plan #: A-05-14-00049; W-00-14-35241; various reviews
Government Program: Office of Audit Services

SUNHAWK CONSULTING

Provider

Physical and Other Therapies

Medicare Part B Payments for Speech-Language Pathology

Expected Issue Date: Completed
Announced: October 2019

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

Work Plan #: W-00-19-35827; W-00-21-35827
Government Program: Office of Audit Services

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Provider

- Multiple Providers
- Hospital
- Long Term Care
- Home Health Service
- Hospice
- Medical Equipment and Supplies
- Physical and Other Therapies
- **Behavioral Health**
- Laboratory
- Prescriber
- Telehealth
- Other Providers and Suppliers

Behavioral Health

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

Expected Issue Date: Completed (partial)
Announced: December 2021

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

Work Plan #: OEI-02-22-00050; OEI-09-21-00410; OEI-02-23-00540
Government Program: Office of Evaluation and Inspections

Medicare Part B Payments for Psychotherapy Services

Expected Issue Date: Completed (partial)
Announced: August 2017

Medicare Part B covers psychotherapy services. Psychotherapy is the treatment of mental illness and behavioral disturbances in which a physician or other qualified health care professional establishes professional contact with a patient and, through therapeutic communication and techniques, attempts to alleviate emotional disturbances, reverse or change maladaptive patterns of behavior, and encourage personality growth and development. In calendar year 2016, Part B allowed approximately $1.2 billion for psychotherapy services, including individual and group therapy. A prior OIG review found that Medicare allowed $185 million in inappropriate outpatient mental health services, including psychotherapy services. The review found that psychotherapy services were particularly problematic, noting that almost half of the psychotherapy services reviewed were inappropriate. Specifically, Medicare paid for services that were not covered, inadequately documented, or medically unnecessary. OIG will review Part B payments for psychotherapy services to determine whether they were allowable in accord with Medicare documentation requirements.

Work Plan #: W-00-17-35801; W-00-21-35801; A-09-21-03021; A-09-18-03004; A-02-19-01012; A-09-19-03018; A-02-21-01005
Government Program: Office of Audit Services

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Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Physical and Other Therapies

Behavioral Health

Laboratory

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Telehealth

Other Providers and Suppliers

Medicaid Targeted Case Management

Expected Issue Date: Completed (partial)
Announced: July 2017

The Social Security Act, § 1915(g)(2), defines case management services as those assisting individuals eligible under the State plan in gaining access to needed medical, social, educational, and other services. Case management services do not include the direct delivery of an underlying medical, educational, social, or other service for which an eligible individual has been referred. Payments for case management services may not duplicate payments made to public agencies under other program authorities for the same service. Prior OIG work in one State identified 18 percent of such claims as unallowable, with an additional 20 percent as potentially unallowable. OIG will determine whether Medicaid payments for targeted case management services in selected States were made in accord with Federal requirements.

Work Plan #: A-07-16-03215; A-07-17-03219; W-00-17-31082; A-07-17-03219; A-07-21-03246; A-07-22-03253
Government Program: Office of Audit Services

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Long Term Care

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Behavioral Health

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Telehealth

Other Providers and Suppliers

Laboratory

Medicare Payments for Clinical Diagnostic Laboratory Tests in 2023

Expected Issue Date: Completed
Announced: July 2024

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

Work Plan #: OEI-09-24-00350
Government Program: Office of Evaluation and Inspections

Audits of Selected Independent Clinical Laboratory Billing Requirements

Expected Issue Date: Completed (partial)
Announced: December 2023

Medicare covers diagnostic clinical laboratory services that are ordered by a physician who is treating a beneficiary and who uses the results in managing the beneficiary's specific medical problem (42 CFR 410.32(a)). These covered services can be furnished in hospital laboratories (for outpatient or nonhospital patients), physician office laboratories, independent laboratories, dialysis facility laboratories, nursing facility laboratories, and other institutions. Previous OIG audits, investigations, and inspections have identified areas of billing for clinical laboratory services that are at heightened risk for noncompliance with Medicare billing requirements. Payments to a service provider are precluded unless the provider furnishes on request the information necessary to determine the amount due (Social Security Act § 1833(e)). OIG will review Medicare payments for clinical laboratory services to determine laboratories' compliance with selected billing requirements. OIG will focus on claims for clinical laboratory services that may be at heightened risk for overpayments. For example, OIG reviews will focus on the improper use of claim line modifiers for a code pair, genetic testing, and urine drug testing services. OIG will use the results of these reviews to identify laboratories or other institutions that routinely submit improper claims, including providers that regularly bill Medicare for definitive drug testing at the highest reimbursement amount allowed.

Work Plan #: A-06-16-02002; A-09-16-02034; A-06-17-04002; A-04-18-08063; A-09-19-03027; A-06-20-04000; A-09-20-03027; A-09-21-03006; A-09-22-03010; W-00-17-35726; W-00-20-35726; W-00-22-35726; W-00-21-35726; W-00-21-35829; W-00-22-35829; WA-24-0023 (W-00-24-35726); various reviews
Government Program: Office of Audit Services

CMS's Emergency Preparedness Related to Clinical Laboratories During the COVID-19 Public Health Emergency

Expected Issue Date: 2025
Announced: August 2022

Laboratory tests are a critically important part of early detection, diagnosis, monitoring, and treatment of disease. During public health emergencies or disasters, CMS has the authority to provide regulatory flexibilities and waivers to ensure that Medicare beneficiaries continue to have access to needed health care. To help health care providers and suppliers prepare for these emergencies or disasters, CMS adopted a final rule (the Emergency Preparedness Rule) in September 2016. The rule required those providers and suppliers to: (1) plan adequately for both natural and manmade disasters; (2) coordinate with Federal, State, Tribal, and regional and local emergency preparedness systems; and (3) adequately prepare to meet the needs of patients during disasters and emergency situations. The rule covers 17 facility types (e.g., hospitals, hospices, and long-term care facilities) but does not cover clinical laboratories. Continued laboratory testing during a public health emergency as well as timely and reliable testing for novel infectious diseases are important for the health of Medicare beneficiaries. Effective testing for novel infectious diseases (including COVID-19) are essential in helping to slow the spread of these diseases by identifying those who are infected and enabling treatment or isolation if needed. OIG will conduct an audit to determine whether CMS's emergency preparedness for clinical laboratories could be improved. Specifically, OIG will look at CMS's emergency preparedness to ensure that: (1) beneficiaries maintain access to all types of laboratory tests, including laboratory tests for novel infectious diseases during a public health emergency, and (2) laboratories have the ability to develop and deliver timely and accurate testing for novel infectious diseases during a public health emergency.

Work Plan #: WA-22-0010 (W-00-22-35889)
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: May 2022

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

Work Plan #: W-00-22-35884
Government Program: Office of Audit Services

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

Expected Issue Date: Completed
Announced: June 2021

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

Work Plan #: W-00-21-35875; W-00-22-35875
Government Program: Office of Audit Services

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

Expected Issue Date: Completed
Announced: February 2021

Laboratory tests are critically important because they are used for early detection, diagnosis, monitoring, and treatment of disease. COVID-19, the disease caused by a new strain of coronavirus that had not been previously identified in humans, first emerged in China in December 2019, and the first reported U.S. case occurred in January 2020. Because of the rapid worldwide spread of the virus, the World Health Organization declared COVID-19 a global pandemic in March 2020. To protect the health and safety of the American people and to assist the Department of Health and Human Services and its Federal partners, laboratories began to provide COVID-19 testing to identify individuals who had contracted the coronavirus that causes COVID-19. Laboratory testing for both COVID-19 tests and non-COVID-19 tests (i.e., laboratory tests that are not for COVID-19) is important for all Medicare beneficiaries, but may be especially important for beneficiaries with certain medical conditions who are identified to be at increased risk for severe illness from COVID-19. Ensuring individuals receive necessary laboratory tests is critical to improving health care quality and containing long-term health costs. OIG's preliminary analysis has shown that the number of non-COVID-19 tests billed for Medicare Part B beneficiaries during the COVID-19 pandemic has decreased compared with the 6-month period before the pandemic, and many independent laboratories have encountered challenges in providing COVID-19 testing. OIG will conduct a series of audits on Medicare Part B laboratory services during the pandemic that will initially focus on

the effect of the pandemic on non-COVID-19 testing. The series of audits will also focus on aberrant billing of COVID-19 testing during the pandemic.

Work Plan #: A-09-21-03004
Government Program: Office of Audit Services

Review of Medicare Part B Urine Drug Testing Services

Expected Issue Date: Completed
Announced: October 2019

Medicare covers treatment services for substance use disorders (SUDs), such as inpatient and outpatient services when they are reasonable and necessary. SUDs occur when the recurrent use of alcohol or other drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Medicare also covers clinical laboratory services, including urine drug testing (UDT), under Part B. Physicians use UDT to detect the presence or absence of drugs or to identify specific drugs in urine samples. A patient in active treatment for an SUD or being monitored during different phases of recovery from an SUD may undergo medical management for a variety of medical conditions. UDT results influence treatment and level-of-care decisions for individuals with SUDs. The 2018 Medicare fee-for-service improper payment data showed that laboratory testing, including UDT, had an improper payment rate of almost 30 percent, and that the overpayment rate for definitive drug testing for 22 or more drug classes was 71.7 percent. OIG will review UDT services for Medicare beneficiaries with SUD-related diagnoses to determine whether those services were allowable in accordance with Medicare requirements.

Work Plan #: A-09-20-03017
Government Program: Office of Audit Services

SUNHAWK CONSULTING

Provider

Prescriber

Medicare Payments for Stelara

Expected Issue Date: Complete (Partial)
Announced: November 2019

Stelara (ustekinumab) is a high-cost prescription biologic approved to treat certain autoimmune diseases. Subcutaneous (under-the-skin) versions of Stelara are typically self-injected and covered under Medicare Part D. Prior to 2023, Medicare Part B also covered subcutaneous versions of Stelara when the injection was administered by a physician; however, Medicare Administrative Contractors now exclude Stelara injections under a policy designed to omit self-administered drugs from Part B coverage. The period during which Stelara was covered under Parts B and D provides a unique opportunity to examine how coverage determinations affect payments made by the Medicare program and costs for its enrollees. OIG will produce two work products related to Medicare payments and utilization trends for the subcutaneous versions of Stelara. The first product will focus on a cost comparison for enrollees with traditional fee-for-service Medicare Part B and standalone Part D drug plans. The second evaluation will focus on Medicare enrollee utilization patterns by setting—Stelara obtained in a physician's office (i.e., where injections would typically be administered by a health care provider) and Stelara obtained through a pharmacy (i.e., where injections would typically be self-administered at home).

Work Plan #: OEI-BL-19-00500; OEI-BL-19-00501; OEI-BL-19-00500
Government Program: Office of Evaluation and Inspections

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

Expected Issue Date: Completed
Announced: November 2016

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

Work Plan #: A-09-17-03002
Government Program: Office of Audit Services

SUNHAWK CONSULTING

Provider

Telehealth

[NEW] Audit of Medicare Part B Remote Patient Monitoring Services

Expected Issue Date: 2026
Announced: December 2024

Medicare Part B remote patient monitoring (RPM) services have the potential to significantly improve health outcomes, but the services warrant additional oversight. RPM services involve the collection of patient physiologic data used to develop and manage a care plan related to a chronic and/or acute health illness or condition. For example, sensors that monitor temperature in a patient's extremities may help prevent diabetic ulcers that can lead to amputations. However, since 2018, the way that providers bill for certain Medicare Part B RPM services has changed significantly, and Medicare payments for those services have increased dramatically. RPM services are also susceptible to fraud, waste, and abuse (e.g., unsolicited device shipments, inadequate monitoring, and inappropriate billing). In November 2023, OIG issued a Consumer Alert about a fraud scheme for RPM services. OIG will determine whether providers furnished and billed for RPM services in accordance with Medicare requirements.

Work Plan #: OAS-25-05-008
Government Program: Office of Audit ServicesCenters for Medicare and Medicaid Services

Use of Remote Patient Monitoring Services in Medicare

Expected Issue Date: Completed (partial)
Announced: April 2023

The use of remote patient monitoring services in Medicare has the potential to exponentially expand. However, there is currently limited research on the use of remote patient monitoring services, such as the types of patients and providers who use these services, and the health conditions that are monitored through these services, among other details. This review will be based on Medicare fee-for-service claims and Medicare Advantage encounter data for remote patient monitoring services. It will look at the extent to which the use of remote patient monitoring services has changed, the nature of remote patient monitoring services being used by Medicare enrollees, and the characteristics of enrollees using remote patient monitoring services. This review will also determine the extent to which provider billing for remote patient monitoring services may indicate fraud, waste, or abuse.

Work Plan #: OEI-02-23-00260; OEI-02-23-00261
Government Program: Office of Evaluation and Inspections

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Physical and Other Therapies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

Audits of Medicare Part B Telehealth Services During the COVID-19 Public Health Emergency

Expected Issue Date: Completed (partial)
Announced: January 2021

Telehealth is playing an important role during the public health emergency (PHE), and CMS is exploring how telehealth services can be expanded beyond the PHE to provide care for Medicare beneficiaries. Because of telehealth's changing role, OIG will conduct a series of audits of Medicare Part B telehealth services in two phases. Phase one audits will focus on making an early assessment of whether services such as evaluation and management, opioid use disorder, end-stage renal disease, and psychotherapy (Work Plan number W-00-21-35801) meet Medicare requirements. Phase two audits will include additional audits of Medicare Part B telehealth services related to distant and originating site locations, virtual check-in services, electronic visits, remote patient monitoring, use of telehealth technology, and annual wellness visits to determine whether Medicare requirements are met.

Work Plan #: W-00-22-35862; W-00-21-35862; A-05-22-00015; A-01-21-00501
Government Program: Office of Audit Services

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[NEW] Medicare Part B Payments for Skin Substitutes

Expected Issue Date: 2026
Announced: November 2024

Skin substitutes help aid in wound healing and redevelopment of skin. Medicare covers skin substitutes that are reasonable and necessary for the treatment of an enrollee's condition. Local coverage determinations state that Medicare Part B generally covers skin substitutes for treatment of diabetic foot ulcers and venous leg ulcers that have failed to respond to at least 4 weeks of standard wound care. However, no national or local coverage requirements apply for other wound types (e.g., pressure ulcers or trauma wounds), and coverage of skin substitutes for these wounds is determined on a case-by-case basis. Medicare Part B pays for skin substitutes based on the number of service units billed at prices ranging from approximately $100 to more than $1,000 per square centimeter. From calendar years 2020 through 2023, Medicare Part B payments for skin substitutes have increased substantially. OIG will review Medicare Part B claims for skin substitutes to identify payments that were at risk for noncompliance with Medicare requirements.

Work Plan #: OAS-25-09-005
Government Program: Office of Audit Services

[NEW] Medicare Part B Payments for Incident-To Services

Expected Issue Date: 2026
Announced: November 2024

Medicare Part B pays for physicians' services and services and supplies "incident to" a physician's services that are furnished by the physician's staff, including non-physician practitioners. Incident to services must be an integral part of the physician's services during diagnosis or treatment of an injury or illness, and, in general, must be furnished under the physician's direct supervision. Incident-to services are billed under the physician's National Provider Identifier number as if the physician personally provided the services. Medicare reimburses the incident to service at the full rate of the Medicare Physician Fee Schedule. Prior OIG work found that improving the transparency of incident-to services is critical to program integrity efforts. OIG's objective is to determine whether Medicare Part B payments for services performed incident to physicians' services complied with Medicare requirements.

Work Plan #: OAS-25-01-003
Government Program: Office of Audit Services

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Joint Pain Management Therapies: Hyaluronic Acid Knee Injections

Expected Issue Date: 2025
Announced: August 2024

Hyaluronic acid, also known as hyaluronan or hyaluronate, is a naturally occurring substance found in the fluid surrounding knee joints. Joints with degenerative joint disease are found to have lower concentrations of hyaluronic acid, resulting in pain, immobility, and reduction of function and the ability to complete activities of daily living. Hyaluronic acid knee injections are used to treat individuals with degenerative joint disease(s) such as knee osteoarthritis. OIG will determine whether Medicare paid physicians for hyaluronic acid injections in accordance with Medicare requirements.

Work Plan #: WA-24-0063 (W-00-24-35921)
Government Program: Office of Audit Services

Medicare Payments for Lower Extremity Peripheral Vascular Procedures

Expected Issue Date: 2025
Announced: June 2024

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

Work Plan #: W-00-24-35914
Government Program: Office of Audit Services

Nationwide Audits of Organ Procurement Organizations and Certified Transplant Centers

Expected Issue Date: 2025
Announced: May 2024

Organ Procurement Organizations (OPOs) are not-for-profit organizations that perform or coordinate the procurement, preservation, and transportation of organs to hospitals for transplantation into patients who are on a waiting list to receive a transplant. Certified Transplant Centers (CTCs) are components within transplant hospitals that provide transplantation of particular types of organs. CTCs are reimbursed by Medicare for certain costs associated with the acquisition of organs from OPOs or other CTCs for transplants involving Medicare patients. Federal regulations (42 CFR part 486, subpart G) include Medicare conditions for coverage for OPOs, and other Federal statutes, regulations, and guidance specify Medicare requirements for the acquisition of organs. Prior OIG audits determined that OPOs did not

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comply with Medicare requirements for reporting overhead costs, administrative and general costs, and organ statistics. OIG will determine whether costs reported by OPOs and CTCs were allowable, reasonable, and according to Medicare requirements, and whether OPOs met required process performance and outcome measures.

Work Plan #: WA-24-0043 (W-00-24-35913)
Government Program: Office of Audit Services

Medicare Part B Payments for Over-the-Counter COVID-19 Tests During the PHE Demonstration

Expected Issue Date: 2025
Announced: August 2023

On April 4, 2022, CMS launched the Medicare Over-the-Counter COVID-19 Test (OTC test) Demonstration (Demonstration) to cover and pay for OTC tests for people with Medicare Part B benefits, including people enrolled in Medicare Advantage plans (enrollee), for the remainder of the COVID-19 Public Health Emergency. During the Demonstration period, Medicare covered for each enrollee up to eight OTC tests per calendar month. If an enrollee received more than eight OTC tests in a calendar month, the enrollee may have had to pay out-of-pocket costs for the extra tests unless the enrollee had additional health coverage. OIG will determine whether Medicare paid eligible pharmacies and health care providers for OTC tests according to the Demonstration.

Work Plan #: WA-23-0034 (W-00-23-35902)
Government Program: Office of Audit Services

Audit of Ambulance Services Supplemental Payment Program

Expected Issue Date: 2025
Announced: July 2023

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

Work Plan #: WA-23-0024 (W-00-23-31570)
Government Program: Office of Audit Services

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

Expected Issue Date: 2025
Announced: April 2021

Medicare covers an Evaluation and Management (E/M) service when the service is reasonable and necessary for the diagnosis or treatment of illness or injury, or to improve the functioning of a malformed body member. Generally, Medicare payments for global surgery procedures include payments for necessary preoperative and postoperative services related to surgery when furnished by a surgeon. Medicare global surgery rules define the rules for reporting E/M services with minor surgery and other procedures covered by these rules. In general, E/M services provided on the same day of service as a minor surgical procedure are included in the payment for the procedure. The decision to perform a minor surgical procedure is included in the payment for a minor surgical procedure and must not be reported separately as an E/M service. An E/M service should be billed only on the same day if a surgeon performs a significant and separately identifiable E/M service that is unrelated to the decision to perform a minor surgical procedure. In this instance, the provider should append a modifier 25 to the appropriate E/M code. In 2019, about 56 percent of dermatologists' claims with an E/M service also included minor surgical procedures (such as lesion removals, destructions, and biopsies) on the same day. This may indicate abuse whereby the provider used modifier 25 to bill Medicare for a significant and separately identifiable E/M service when only a minor surgical procedure and related preoperative and postoperative services are supported by the beneficiary's medical record. OIG will determine whether dermatologists' claims for E/M services on the same day of service as a minor surgical procedure complied with Medicare requirements.

Work Plan #: W-00-21-35868
Government Program: Office of Audit Services

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

Expected Issue Date: Completed (partial)
Announced: June 2019

Medicare Part B covers ophthalmology services that are reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Ophthalmology services include intravitreal injections of Eylea and Lucentis to treat eye diseases such as wet age-related macular degeneration. Medicare pays for an intravitreal injection (which is considered a minor surgery) as part of a global surgical package that includes the preoperative, intraoperative, and postoperative services routinely performed by the physician. Medicare pays for Eylea and Lucentis separately from the intravitreal injection. Chapter 12, section 40.1 of the Centers for Medicare & Medicaid Services' Medicare Claims Processing Manual states that separate payment can be made for other services provided by the same physician on the same day as the global surgery if the services are significant and separately identifiable or unrelated to the surgery. OIG will review claims for intravitreal injections of Eylea and/or Lucentis and the other services billed on the same day as the injection, including evaluation and management services, to determine whether the services were reasonable and necessary and met Medicare requirements.

Work Plan #: A-09-19-03022; A-09-19-03025; W-00-19-30100; W-00-22-30100
Government Program: Office of Audit Services

Medicare Part B Payments for Podiatry and Ancillary Services

Expected Issue Date: 2025
Announced: February 2019

Medicare Part B covers podiatry services for medically necessary treatment of foot injuries, diseases, or other medical conditions affecting the foot, ankle, or lower leg. Part B generally does not cover routine foot-care services such as the cutting or removal of corns and calluses or trimming, cutting, clipping, or debridement (i.e., reduction of both nail thickness and length) of toenails. Part B may cover these services, however, if they are performed (1) as a necessary and integral part of otherwise covered services, (2) for the treatment of warts on the foot, (3) in the presence of a systemic condition or conditions, or (4) for the treatment of infected toenails. Medicare generally does not cover evaluation and management (E&M;) services when they are provided on the same day as another podiatry service (e.g., nail debridement performed as a covered service). However, an E&M; service may be covered if it is a significant separately identifiable service. In addition, podiatrists may order, refer, or prescribe medically necessary ancillary services such as x-rays, laboratory tests, physical therapy, durable medical equipment, or prescription drugs. Prior OIG work identified inappropriate payments for podiatry and ancillary services. OIG will review Part B payments to determine whether podiatry and ancillary services were medically necessary and supported in accordance with Medicare requirements.

Work Plan #: W-00-19-35818; W-00-21-35818
Government Program: Office of Audit Services

Physicians Billing for Critical Care Evaluation and Management Services

Expected Issue Date: Completed (partial)
Announced: August 2018

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

Work Plan #: A-03-18-00003; W-00-18-35816; W-00-22-35816; A-03-20-00002; various reviews
Government Program: Office of Audit Services

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

Expected Issue Date: Completed
Announced: June 2018

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

Work Plan #: A-05-20-00010
Government Program: Office of Audit Services

Ambulance Services - Supplier Compliance with Payment Requirements

Expected Issue Date: Completed (partial)
Announced: November 2016

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

Work Plan #: A-02-16-01021; A-09-17-03018; W-00-17-35574; W-00-22-35574; various reviews
Government Program: Office of Audit Services