Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Provider-Focused Audits Summary

February 1, 2022 - February 28, 2025

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To our Compliance Colleagues and Partners:

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

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

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

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Provider

Multiple Providers

CMS Recovered Medicare Payments to Providers Under the COVID-19 Accelerated and Advance Payments Program in Compliance With Federal Requirements

- The Centers for Medicare & Medicaid Services (CMS) disbursed more than $103 billion in COVID-19 Accelerated and Advance Payments (CAAP) Program payments to more than 46,000 providers.
- COVID-19 created extraordinary challenges for the delivery of health care and human services to the American people. As the oversight agency for Health and Human Services (HHS), the Office of Inspector General (OIG) oversaw HHS's COVID-19 response and recovery efforts. This audit was part of OIG's COVID-19 response strategic plan.
- This audit determined whether CAAP Program payments were recovered in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements. As of the end of OIG's fieldwork, of the 100 sampled providers totaling $4.4 billion in CAAP Program payments, the Medicare Administrative Contractors completed recovery from 97 sampled providers and continued the recovery from the remaining 3 providers.

OIG concluded that CMS recovered the CAAP Program payments made to providers in compliance with the repayment terms of the Continuing Appropriations Act, 2021 and Other Extensions Act and other Federal requirements. Therefore, OIG did not have any recommendations.

Audit #: A-05-23-00005 (09/17/2024)
Government Program: CMS

Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers

- Medicare providers were required to submit to their Medicare administrative contractor (MAC) annual cost reports, which were financial documents that conveyed the provider's costs associated with providing services to Medicare enrollees. MACs used them to determine the final amount of Medicare program reimbursement due providers for their cost reporting period (the final settlement of the cost report).
- MACs could audit a provider's cost report after performing a mandatory desk review to further verify compliance with the law, regulations, and Medicare manual instructions relating to the final settlement of the cost report.
- CMS's primary goal was for the MACs to arrive at correct final settlements of the cost report. If there was an error made in the final settlement, the cost report final settlement could be reopened and adjusted to correct for the error. OIG performed this audit of one MAC, Novitas Solutions, Inc. (Novitas), to determine whether Novitas reopened and corrected cost report final settlements because of obvious errors in their audits.

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Novitas reopened 8 of 281 (2.8 percent) audited cost reports to correct the final settlements that contained obvious errors. These 8 audited cost reports required 10 reopenings because of human errors by Novitas.

OIG found that:

- As a result of these 10 errors, the reopened cost reports resulted in corrected final settlements to providers totaling $1.1 million in net overpayments, consisting of $1.4 million in overpayments and $285,076 in underpayments.
- Auditors and supervisors required additional education on the criteria and audit requirements applicable to certain payments and bad debts. Novitas' procedures for review by supervisors did not detect the incorrect audit adjustments.
- The risk existed that delays in the finalization of audited cost reports could have prevented some Medicare funds from being expended in the most efficient and effective ways.

OIG recommended that Novitas:

1. develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements and
2. develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect audit adjustments.

Audit #: A-06-23-05001 (09/11/2024)
Government Program: CMS

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

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

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

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

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

selected a statistical sample of 150 providers (each represented by a TIN).

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-09-22-06001 (03/04/2024)
Government Program: HRSA

A Resource Guide for Using Medicare's Enrollment Race and Ethnicity Data

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

Evaluation #: OEI-02-21-00101 (06/27/2023)
Government Program: CMS

Providers Did Not Always Comply With Federal Requirements When Claiming Medicare Bad Debts

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

For the second objective, OIG found that the 67 selected providers' policies and procedures for collecting from

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

beneficiaries Medicare deductible and coinsurance amounts that providers claimed as Medicare bad debts complied with Federal requirements. These policies and procedures were similar to the providers' policies and procedures for collecting non-Medicare bad debts.

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

Audit #: A-07-20-02825 (12/15/2022)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

The CAAP Program payments made to the three providers under bankruptcy occurred because two MACs did not

correctly match the provider's request against their bankruptcy databases, and one MAC did not update its bankruptcy database based on bankruptcy information that was provided by CMS prior to approving the CAAP Program payment request.

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

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

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

Selected Dialysis Companies Implemented Additional Infection Control Policies and Procedures To Protect Beneficiaries and Employees During the COVID-19 Pandemic

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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[NEW] Medicare Could Save Billions With Comparable Access for Enrollees if Critical Access Hospital Payments for Swing-Bed Services Were Similar to Those of the Fee-for-Service Prospective Payment System

- Congress established the Rural Flexibility Program, which created Critical Access Hospitals (CAHs), to ensure that enrollees in rural areas had access to a range of hospital services.
- CAHs provided "swing-bed" services, which were similar to services performed at a skilled nursing facility (SNF).
- Medicare reimbursed CAHs at 101 percent of their reasonable costs rather than at rates set by Medicare's prospective payment system (PPS) or Medicare's fee schedules.
- A prior Office of Inspector General report issued in 2015 recommended that CMS seek legislation to adjust CAH swing-bed reimbursement rates to the lower SNF PPS rates paid for similar services at alternative facilities. The recommendation remained open and unimplemented.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Swing-bed utilization for skilled nursing services at CAHs increased by 2.8 percent from CY 2015 through 2020; meanwhile, the average daily reimbursement amount increased by 16.6 percent over the same period.
- Based on OIG's sample results, it was found that 87 of 100 sampled CAHs were within a 35-mile driving distance of an alternative facility that had skilled nursing care available and estimated that 1,128 of the 1,297 CAHs in OIG's sampling frame had an alternative facility within 35 miles that could have provided care during CY 2020.
- Based on OIG's sample results and mathematical calculation, it was estimated that Medicare could have saved up to $7.7 billion over a 6-year period if payments made at CAHs were reimbursed using SNF PPS rates.

OIG recommended that CMS seek a legislative change that would allow it to reimburse CAHs at rates that aligned with those paid to alternative facilities when it determined that similar care was available at alternative facilities.

Audit #: A-05-21-00018 (12/31/2024)
Government Program: CMS

Texas Generally Claimed Medicaid Reimbursement for Fee-for-Service Inpatient Hospital Claims With Malnutrition Diagnosis Codes in Accordance with Federal and State Requirements

- A previous OIG audit found that hospitals nationwide had incorrectly billed the Medicare program by using severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or used no malnutrition diagnosis code at all.
- Incorrectly using malnutrition diagnosis codes can result in a higher payment for the claim.
- This audit assessed Medicaid fee-for-service (FFS) inpatient hospital claims with malnutrition diagnosis codes to determine whether Texas claimed reimbursement in accordance with Federal and State requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Texas claimed reimbursement in accordance with Federal and State requirements for 88 of 100 sampled FFS inpatient hospital claims with malnutrition diagnosis codes. However, the remaining 12 sampled claims did not comply with Federal and State requirements.

- For 10 sampled claims, the associated medical record documentation did not support the malnutrition diagnosis code; however, the use of the diagnosis code did not impact the Medicaid payment amount.
- For two sampled claims, the State agency improperly claimed $9,213 ($5,478 Federal share).

OIG concluded that this report did not contain recommendations.

ICD Codes Identified in This Audit:

- E43 - unspecified severe protein-calorie malnutrition
- E46 - unspecified protein-calorie malnutrition
- E440 - moderate protein-calorie malnutrition
- E441 - mild protein-calorie malnutrition

Audit #: A-06-22-04002 (11/26/2024)
Government Program: CMS

Not All Selected Hospitals Complied With the Hospital Price Transparency Rule

- Health care spending was projected to account for almost 20 percent of the American economy by 2027.
- CMS believed that one reason for this upward spending trajectory was the lack of transparency in health care pricing, and that improving transparency would increase market competition and drive down the cost of health care services.
- Several media reports stated that hospitals appeared slow to comply with CMS's Hospital Price Transparency rule (HPT rule). Members of Congress expressed concern that some hospitals were either not taking any action to comply with the requirements of the HPT rule or were acting slowly.
- This audit assessed whether selected hospitals made their standard charges available to the public as required by Federal law.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all of the selected hospitals made their standard charges available to the public as required by Federal law. Of the 100 hospitals in the stratified random sample, 63 complied with the HPT rule requirements; however, 37 did not comply with 1 or both of the following HPT rule requirements:

- 34 hospitals did not comply with 1 or more of the requirements associated with publishing comprehensive machine-readable files.

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

- 14 hospitals did not comply with 1 or more of the requirements associated with displaying shoppable services in a consumer-friendly manner.

  On the basis of the sample results, OIG estimated that 46 percent of the 5,879 hospitals that were required to comply with the HPT rule did not comply with the requirements to make information on their standard charges available to the public.

OIG recommended that CMS:
1. review noncompliant hospitals associated with OIG's findings and, if CMS determined that the hospitals were noncompliant, execute CMS's enforcement measures as applicable;
2. use the information in this report and consider implementing changes suggested by hospitals, including providing written guidance clarifying the definition of "shoppable services" and developing a training and compliance program that was tailored for smaller hospitals; and
3. continue to strengthen its internal controls, to include allocating sufficient resources to maintain a robust program of reviews of the hospitals and their compliance with the HPT rule.

Audit #: A-07-22-06108 (11/05/2024)
Government Program: CMS

Medicare Improperly Paid Hospitals an Estimated $79 Million for Enrollees Who Had Received Mechanical Ventilation

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare payments to hospitals for inpatient claims with certain MS-DRGs that required more than 96 consecutive hours of mechanical ventilation did not fully comply with Medicare requirements. For 233 of 250 sampled claims, Medicare payments to hospitals complied with requirements. However, for the 17 remaining sampled claims, Medicare payments to hospitals did not comply with requirements. Specifically, hospitals used incorrect procedure or diagnosis codes. For eight sampled claims, hospitals incorrectly used the procedure code for more than 96 hours of

mechanical ventilation when enrollees had not received more than 96 hours of mechanical ventilation. For nine sampled claims, hospitals used incorrect diagnosis codes or incorrectly used a procedure code that was not related to mechanical ventilation. Consequently, the 17 sampled claims were assigned incorrectly to MS-DRGs 207 or 870, resulting in $382,032 of overpayments.

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

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

ICD Codes Identified in This Audit:

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

Audit #: A-09-22-03002 (08/09/2024)
Government Program: CMS

CMS Could Strengthen Program Safeguards To Prevent and Detect Improper Medicare Payments for Short Inpatient Stays

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

OIG recommended that CMS work with its contractors to:

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

  The full text of the recommendations was in the report.

ICD Codes Identified in This Audit:

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

Audit #: A-09-21-03022 (06/11/2024)
Government Program: CMS

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

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

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

2020, for enrollees diagnosed with COVID-19.

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

ICD Codes Identified in This Audit:

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

Audit #: A-09-21-03009 (12/13/2023)
Government Program: CMS

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

Medicare Could Save Millions if It Implements an Expanded Hospital Transfer Payment Policy for Discharges to Postacute Care

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-01-21-00504 (10/06/2023)
Government Program: CMS

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

OIG recommended that CMS:

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

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

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

Audit #: A-09-23-03016 (09/08/2023)
Government Program: CMS

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

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

In April 2020, the U.S. Department of Health and Human Services (HHS) began distributing Provider Relief Fund (PRF) payments through the Health Resources and Services Administration (HRSA) to support health care providers, including hospitals, on the front line of the pandemic response. To respond to the urgent need for health care funding, Congress required HHS to make PRF payments using the most efficient payment systems practicable. HHS had to make decisions quickly about how to allocate money in accordance with statutory criteria associated with the funds.

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

To analyze hospital funding according to populations served, OIG took allocations to hospitals from the Targeted PRF in 2020 and translated them into estimated "PRF per person" amounts for each U.S. census tract (in this report, OIG also referred to census tracts as "communities"). To do so, OIG used Medicare data about the census tracts served by each hospital, and assigned each hospital's funding allocations to those census tracts proportionately. OIG then determined whether there were statistically significant correlations between PRF per person and the racial, ethnic, and economic composition of the census tracts. To account for other community characteristics that could help explain differences in PRF per person, OIG analyzed rural and nonrural census tracts separately. OIG conducted this analysis for the approximately $44 billion in Targeted PRF allocated to hospitals in 2020 through the four allotments designated for:
1. COVID-19 High Impact Area Hospitals
2. Safety Net Hospitals
3. Rural Hospitals
4. Indian Health Service and Tribal Hospitals.

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

Audit #: A-01-21-01502 (01/13/2023)
Government Program: ASPR

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that of the 387 improperly paid claims identified in OIG's previous 12 hospital compliance audits, 333 were inpatient claims that resulted in $5,260,147 in net overpayments, and 54 were outpatient claims that resulted in $53,729 in net overpayments. Of these 387 improperly paid claims, 229 claims were appealed at the first level, of which 22 overpayment determinations were overturned. In addition, 126 claims were appealed at the second level, of which 6

overpayment determinations were overturned. As a result, 359 overpayment determinations remained, resulting in sustained overpayments totaling $5,041,721. After considering the results of the first and second levels of appeal, OIG determined that the total overpayments received by the 12 hospitals was $82 million.

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

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

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

Medicare Part B Overpaid and Beneficiaries Incurred Cost-Share Overcharges of Over $1 Million for the Same Professional Services

OIG performed survey work on calendar year 2019 Medicare Part B claims and found that Critical Access Hospitals (CAHs) were paid for professional services provided by health care practitioners that received payment for the same services provided at the CAH. Generally, Medicare should not pay both a CAH and health care practitioner for professional services.

OIG's objective was to determine whether Medicare Part B payments to CAHs for professional services and payments made to health care practitioners for the same services complied with Federal requirements.

OIG's audit covered 40,026 Medicare Part B claims, 20,013 claims submitted by CAHs and 20,013 claims submitted by health care practitioners, for the same professional services provided to the same beneficiaries on the same dates of service from March 1, 2018, through February 28, 2021 (audit period). Medicare paid CAHs $1.0 million and paid health care practitioners $872,858 for these 40,026 claims.

OIG reviewed Federal requirements for reassigning professional billing rights to CAHs. To conduct the audit, OIG used data analysis techniques to identify overpayments for professional billing by both the CAH and the health care practitioner.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all Medicare Part B payments made to CAHs for professional services and payments made to health care practitioners complied with Federal requirements. For the 40,026 claims audited, CAHs and health care practitioners each submitted an equal number of claims. However, for each date of service, only one of the claims complied with Federal requirements. As a result, Medicare administrative contractors (MACs) paid providers $907,438 more than they should have been paid, and beneficiaries were held responsible for $281,321 more than they should have been.

These overpayments occurred because CMS did not have claim system edits to prevent and detect duplicate professional services claims for the same date of service, beneficiary, and procedure.

OIG recommended that CMS (1) direct the MACs to recover the $331,448 from the CAHs for 12,156 claims for which the health care practitioners had not reassigned their billing rights to the CAHs and $83,412 in cost-sharing overcharges to Medicare beneficiaries that were within the 4-year reopening period and (2) direct the MACs to recover the $575,990 from health care practitioners for 7,857 claims for which the health care practitioners had reassigned their billing rights to the CAHs and $197,909 in cost-sharing overcharges to beneficiaries that were within the 4-year reopening period. See the audit report for additional recommendations.

CPT Codes Identified in This Audit:

- 52235 - Cystourethroscopy, With Fulguration and/or Resection
- 66984 - Intraocular Lens Procedure
- 93010 - Electrocardiogram
- 99215 - Established Patient Office or Other Outpatient Services
- 49505 - Repair Initial Inguinal Hernia, age 5 Years or Older

Audit #: A-06-21-05003 (09/19/2022)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

CPT Codes Identified in This Audit:

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

Audit #: A-03-20-00002 (07/19/2022)
Government Program: CMS

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

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

eligibility for, and the amount of, outlier payments for transfer claims.

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-05-19-00019 (07/05/2022)
Government Program: CMS

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

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

OIG's objective was to identify the potential cost savings to both the Medicare program and its beneficiaries by comparing their payments made for certain evaluation and management (E&M) services performed at provider-based

facilities in calendar years 2010 through 2017 in eight selected States with what Medicare and beneficiaries would have paid for the same type of services performed at freestanding facilities in the same eight States.

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

The Centers for Medicare & Medicaid Services (CMS) had taken some steps intended to equalize payments. If these changes had been in effect during the period covered by the audit, the potential cost savings of these changes for E&M; services in the selected States for the audit period could have been a combined $1.4 billion for the Medicare program and its beneficiaries. However, the combined $1.4 billion in potential cost savings would still have been less than the $1.6 billion in potential cost savings if E&M; services had been paid at the freestanding PFS nonfacility rate.

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

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

CPT Codes Identified in This Audit:

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

HCPCS Codes Identified in This Audit:

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

Audit #: A-07-18-02815 (06/10/2022)
Government Program: CMS

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Vanderbilt University Medical Center: Audit of Outpatient Outlier Payments

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that VUMC properly billed the claims for 34 of the 117 sampled outlier payments totaling $102,551. However, VUMC did not properly bill the claims related to 81 outlier payments, resulting in improper outlier payments during OIG's audit period. These 81 claims, which had outlier payments totaling $427,644, contained 110 billing errors. The billing errors primarily occurred because VUMC did not have adequately designed controls or billing system capabilities to prevent coding errors, charge errors, and billing for services not covered by Medicare Part B. VUMC billed another two claims with incorrect dates of service that caused the claims to fall outside the scope of this audit (outpatient services longer than 1 day) and so were classified as non-errors.

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

Audit #: A-06-20-04003 (05/25/2022)
Government Program: CMS

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

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

OIG conducted a new study to update the national incidence rate of patient harm events among hospitalized Medicare

patients in October 2018. This work included calculating a new rate of preventable events and updating the cost of patient harm to the Medicare program.

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

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

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

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

Stage 2: Physicians reviewed the records flagged during Stage 1 as containing possible harm events. Physician-reviewers identified harm events and assessed the severity of events, whether events were preventable, and factors that contributed to events.

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

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

Evaluation #: OEI-06-18-00400 (05/05/2022)
Government Program: AHRQ, CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Provider

- Multiple Providers
- **Hospital**
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- Medical Equipment and Supplies
- Behavioral Health
- Laboratory
- Telehealth
- Other Providers and Suppliers

CPT Codes Identified in This Audit:

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

ICD Codes Identified in This Audit:

- E66.01 - Morbid obesity

Audit #: A-09-20-03007 (02/22/2022)
Government Program: CMS

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Provider

Long Term Care

[NEW] Some Selected Skilled Nursing Facilities Did Not Comply With Medicare Requirements for Reporting Related-Party Costs

- Most of the approximately 15,000 nursing homes in this country were certified by Medicare to serve as skilled nursing facilities (SNFs). As of FY 2023, about 1.2 million people resided in nursing homes.
- SNFs filed cost reports with Medicare. Accurate cost reports were important because cost reports provided the Medicare program with transparency about the costs SNFs incurred in providing care for residents and with critical information that CMS used to update SNF payment rates.
- SNFs and other Medicare providers regularly obtained services, facilities, or supplies (e.g., therapy services for SNF residents) from parties related to the provider (related parties).
- SNFs and other providers had to report related parties and related-party costs on their cost reports. Compliance with Medicare cost reporting requirements ensured that SNFs were not reporting related-party costs in excess of what was allowable.
- For Medicare cost reporting periods ending during FYs 2015 through 2020, SNFs reported receiving a total of $160.4 billion in Medicare payments and paying a total of $65.4 billion to related parties.
- This audit examined whether selected SNFs reported related parties as required and whether their related-party costs complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- Of the 14 SNFs in the nonstatistical sample, 3 SNFs did not properly disclose 1 or more related parties on their Medicare cost reports. In addition, 7 of the 14 SNFs did not properly adjust some of their related-party costs to Medicare-allowable costs as required, which resulted in more than $1.7 million in overstated costs.
- Medicare administrative contractors (MACs) did not review, as part of their oversight activities, the disclosure or reporting of related parties and their costs, and CMS did not provide sufficient guidance to SNFs that explained how to determine Medicare-allowable related-party costs.

OIG recommended that CMS:
1. require the MACs to include, as part of the normal desk review or audit process, a review of reporting and disclosure of related-party costs;
2. develop and implement guidance for SNFs on the appropriate methods for providers to determine their allowable related-party costs; and
3. provide guidance to reeducate MACs on the need to review, grant, and document requests from SNFs for exceptions to cost reporting requirements in compliance with 42 CFR SS 413.17(d).

Audit #: A-07-21-02836 (12/18/2024)
Government Program: CMS

[NEW] Nonprofit and Government-Owned Nursing Homes Generally Complied With Federal Requirements Regarding the Infection Preventionist Position

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that three nonprofit and two Government-owned nursing homes may not have complied with the requirement that the IPs complete specialized infection prevention and control training prior to assuming the IP role. On the basis of OIG's sample results, OIG estimated that 117 nursing homes nationwide (99 of 3,294 nonprofit and 18 of 922 Government-owned) may not have complied with Federal regulations pertaining to IPs during the audit period. As a result, there may have been increased health and safety risks for the residents and staff of these nursing homes.

OIG recommended that the Centers for Medicare & Medicaid Services instruct the State survey agencies to follow up with the five nursing homes (three nonprofit and two Government-owned) that may not have complied with Federal requirements to verify that they had taken corrective actions.

Audit #: A-01-24-00002 (12/02/2024)
Government Program: CMS

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

- As many as 70 percent of seniors may need care in long-term care settings at some point in their lives. In 2023, nearly 16 percent of residents living in long-term care settings reported experiencing abuse.
- In 2010, the Patient Protection and Affordable Care Act (the Act) established a National Background Check Program, which provided Federal financial assistance for States to develop or enhance systems for long-term care settings to conduct background checks on prospective employees.
- Twenty-nine States participated in the program at various times from 2010 to 2024. The last two States ended participation on May 31, 2024.
- The Act included a mandate for OIG to produce an evaluation of this program.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that the National Background Check Program successfully established a program to help States identify efficient, effective, and economical procedures for conducting background checks on prospective long-term care employees. The National Background Check Program helped States successfully build systems to disqualify employees with concerning criminal convictions from working in long-term care settings. States reported two procedures that were appropriate, efficient, and effective for conducting background checks: having an automated system for conducting background checks and having the ability to monitor status changes to a person's background check after the initial background check has been completed. States rarely reported that conducting background checks resulted in any unintended consequences, such as a reduction in workforce. The most common challenges that States encountered

while in the program were a lack of State legislative authority and difficulty coordinating between State-level departments. States spent more than $100 million in combined Federal and State funds to develop or enhance systems to conduct background checks of potential employees of long-term care providers.

OIG concluded that OIG issued recommendations during the program that aided the outcomes in this final assessment. OIG did not have further recommendations for CMS.

Evaluation #: OEI-07-24-00100 (11/04/2024)
Government Program: CMS

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

- Nursing homes that participated in Medicare and Medicaid were required by CMS to comply with requirements intended to protect residents, including requirements related to sprinkler systems, smoke detector coverage, and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In Massachusetts, the State's Department of Public Health conducted surveys of nursing homes to ensure compliance with Federal requirements.
- This audit was one in a series of audits that assessed compliance with Federal requirements for life safety, emergency preparedness, and infection control.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 236 deficiencies related to life safety, emergency preparedness, or infection control were identified at the 20 nursing homes in Massachusetts that they reviewed. These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency, or in the event of an infectious disease outbreak.

OIG recommended that Massachusetts improve the health and safety of residents, staff, and visitors at nursing homes by following up with the 20 nursing homes where OIG identified deficiencies to ensure that they had taken corrective actions. Additionally, OIG recommended that Massachusetts work with CMS to identify nursing homes requiring frequent inspections. The full recommendations were in the report.

Audit #: A-01-23-00003 (10/04/2024)
Government Program: CMS

Certain For-Profit Nursing Homes May Not Have Complied With Federal Requirements Regarding the Infection Preventionist Position

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

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- This audit examined whether for-profit nursing homes nationwide complied with Federal requirements pertaining to IPs.

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

Audit #: A-01-22-00001 (08/19/2024)
Government Program: CMS

Florida Ensured That Nursing Homes Complied with Federal Background Check Requirements

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

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

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

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

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SunHawk Summary of OIG Audit Findings and Recommendations

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

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

Audit #: A-04-23-08100 (04/26/2024)
Government Program: CMS

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

- **Nursing homes sometimes fell short in providing required documentation**, such as documentation that the receiving facility could provide services that met residents' needs.
- **Nursing homes often failed to notify residents of their discharges and frequently omitted required information in notices**, which may have compromised residents' rights and abilities to plan for safe transitions.
- **Even when nursing homes provided the resident with a facility-initiated discharge notice, only about half sent a copy of the notice to the Ombudsman, as required**, potentially impeding the Ombudsman's ability to effectively advocate for residents.

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

OIG concluded that:

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

Evaluation #: OEI-01-18-00251 (03/29/2024)
Government Program: CMS

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

Evaluation #: OEI-01-18-00252 (03/29/2024)
Government Program: CMS

Lessons Learned During the Pandemic Can Help Improve Care in Nursing Homes

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

1. Implement and expand upon its policies and programs to strengthen the nursing home workforce.

2. Reassess nurse aide training and certification requirements.

3. Update the nursing home requirements for infection control to incorporate lessons learned from the pandemic.

4. Provide effective guidance and assistance to nursing homes on how to comply with updated infection control requirements.

5. Facilitate sharing of strategies and information to help nursing homes overcome challenges and improve care.

Evaluation #: OEI-02-20-00492 (02/26/2024)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

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

Evaluation #: OEI-06-22-00030 (01/08/2024)
Government Program: CDC

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

HCPCS Codes Identified in This Audit:

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

Audit #: A-05-22-00019 (12/20/2023)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

Audit #: A-09-22-02006 (12/08/2023)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-06-21-02000 (11/29/2023)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

Audit #: A-03-22-00206 (11/08/2023)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-02-22-01004 (09/29/2023)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-04-22-08093 (09/06/2023)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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Other Providers and Suppliers

activities with multiple community partners.

Evaluation #: OEI-06-22-00100 (09/01/2023)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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Audit #: A-09-20-02007 (04/10/2023)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

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

The administration recently announced a major initiative to improve safety and quality of care in nursing homes. The findings in this report lent urgency to the administration's initiative. OIG recommended that CMS, as it supported the administration's initiative, take the following actions:
(1) reexamine current nursing staff requirements and revise them as necessary;
(2) improve how surveys identified infection control risks to nursing home residents and strengthen guidance on assessing the scope and severity of those risks; and
(3) target nursing homes in most need of infection control intervention, and provide enhanced oversight and technical assistance to these facilities as appropriate.

ICD Codes Identified in This Evaluation:

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

Evaluation #: OEI-02-20-00491 (01/12/2023)
Government Program: CMS

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Long-Term Trends of Psychotropic Drug Use in Nursing Homes

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

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

OIG recommended that CMS should:

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

Evaluation #: OEI-07-20-00500 (11/10/2022)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

- leadership turnover,
- staff turnover,

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

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

Audit #: A-01-20-00004 (09/15/2022)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

Audit #: A-01-20-00005 (07/26/2022)
Government Program: CMS

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-02-21-01010 (07/15/2022)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

Audit #: A-09-22-02003 (06/23/2022)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

Evaluation #: OEI-07-20-00181 (05/12/2022)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

Audit #: A-05-20-00005 (04/07/2022)
Government Program: CMS

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Provider

Home Health Service

[NEW] Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, the first of a nationwide series of home health audits, examined whether Bridge Home Health complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Bridge Home Health complied with Medicare billing requirements for 90 of the 100 home health claims OIG reviewed. For the remaining 10 claims, Bridge Home Health incorrectly billed Medicare for claims with unsupported codes, invalid face-to-face encounters, and skilled services that did not meet requirements.

- Six claims did not meet billing and coding requirements, resulting in a net underpayment totaling $291.
- Three claims did not meet face-to-face requirements, resulting in overpayments totaling $6,337.
- One claim did not meet skilled need requirements but did not result in an overpayment.

Bridge Home Health received net overpayments totaling $6,046 for the claims in the sample.

OIG recommended that Bridge Home Health: (1) refund the $6,046 in overpayments to the Medicare program; (2) identify similar instances of noncompliance that occurred before, during, and after the audit period and determine the impact and return any overpayments to the Federal Government; and (3) strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

Audit #: A-05-23-00017 (12/19/2024)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

HCPCS Codes Identified in This Audit:

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

Audit #: A-05-21-00026 (09/25/2023)
Government Program: CMS

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

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Telehealth

Other Providers and Suppliers

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

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Laboratory

Telehealth

Other Providers and Suppliers

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

CMS had an opportunity to assess how to best help HHAs prepare for and respond to future emergencies, as well as to evaluate how changes to the home health landscape could better serve patients. To that end, OIG recommended that CMS evaluate how HHAs were using telehealth—specifically, the types of services provided via telehealth and the characteristics of patients who benefited from these services. OIG also recommended that CMS—to inform decision-making—evaluate how the regulatory flexibilities it had offered in response to the COVID-19 public health emergency affected the quality of home health care. Finally, OIG recommended that CMS—in collaboration with the Administration for Strategic Preparedness and Response's (ASPR's) Technical Resources, Assistance Center, and Information Exchange (TRACIE)—apply lessons learned from the COVID-19 pandemic to update and/or develop

emergency preparedness trainings and materials for HHAs on responding to infectious disease outbreaks.

Evaluation #: OEI-01-21-00110 (10/14/2022)
Government Program: CMS

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Provider

Hospice

CGS Administrators, LLC, Did Not Reopen and Recalculate Most Selected Hospices' Caps for Years Prior to 2020

- Payments made to hospices were limited by inpatient cap and aggregate cap amounts that represented the maximum amount of Medicare payments a hospice could have received for a cap year. The cap amounts were calculated annually, and any amount paid to a hospice above either cap amount was an overpayment and had to be repaid to Medicare.
- Medicare administrative contractors (MACs) completed the hospice cap calculations for the inpatient and aggregate cap after the end of the cap year. Cap calculations were subject to CMS reopening regulations, which allowed reopening for up to 3 years from the date of the cap calculation.
- OIG's audit determined whether CGS accurately calculated cap amounts and collected cap overpayments in accordance with CMS requirements.
- This audit was part of a series that reviewed MAC calculations and collections of hospice aggregate and inpatient cap overpayments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- CGS accurately calculated the initial 2020 cap amounts for all 805 hospices that operated in its jurisdiction and collected or attempted to collect the $9.1 million in cap overpayments it identified. However, for 45 selected hospices, CGS did not reopen and recalculate most hospice caps for prior cap years (i.e., 2017, 2018, and 2019), which limited CGS's overpayment identification and collection for those prior years.
- Because CGS missed cap reopening deadlines and failed to revisit prior years' cap calculations for hospices with Unified Program Integrity Contractor (UPIC) recoupments, it did not calculate and collect additional overpayments totaling $201,873 for prior cap years.

OIG recommended that CGS:
1. discontinue its practices that limited the reopening of prior years' cap calculations and start reopening all prior years' cap calculations,
2. revise policies and procedures so that it met the reopening deadlines established in the Federal requirements, and
3. conduct the prior years' hospice cap calculations for the five hospices with UPIC recoupments and collect any additional overpayments.

Audit #: A-06-23-09003 (11/27/2024)
Government Program: CMS

Seven of Thirty Hospices Reviewed Did Not Comply or May Not Have Complied With Terms and Conditions and Federal Requirements for Provider Relief Fund Payments

- The Provider Relief Fund (PRF), a $178 billion program, provided funds to eligible providers for health care-related expenses or lost revenue attributable to COVID-19. HHS was responsible for initial PRF program oversight and policy decisions, and HRSA administered the PRF program.
- Providers receiving PRF payments were to ensure that the payments were: (1) used to prevent, prepare for, or respond to COVID-19; (2) used for health care-related expenses or lost revenues attributable to COVID-19; (3) not used to cover expenses or losses reimbursed by other funding sources; and (4) not used to pay salaries in excess of a certain threshold or to pay for certain prohibited activities.
- This audit was part of a series reviewing PRF payments to various provider types. Specifically, this audit assessed whether 30 selected hospices expended taxpayer funds in accordance with Federal and program requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- The selected hospices reported that they had used $80.2 million of their PRF payments to offset lost revenues, $89.8 million for general and administrative expenses, and $34.8 million for health care-related expenses.
- Of the 30 selected hospices, 23 hospices had used PRF funds for allowable expenditures and lost revenues attributable to COVID-19; however, 7 hospices did not comply with or may not have complied with Federal requirements. Of these seven hospices, which received $98.1 million in PRF payments, six hospices had claimed a total of $8.3 million of unallowable PRF expenditures and inaccurately reported $1.5 million of lost revenues, and one hospice had claimed $4 million in expenditures that may not have been allowable.
- These deficiencies occurred because although HRSA provided the PRF terms and conditions and updated its guidance to PRF recipients, the hospices did not always maintain documentation for expenses claimed, correctly interpret HRSA guidance, have procedures to verify the accuracy of lost revenue calculations, or track expenses funded by PRF payments.

OIG recommended that HRSA require the selected hospices to return any unallowable expenditures to the Federal Government or ensure that the hospices properly accounted for these expenditures.

Audit #: A-02-22-01014 (11/08/2024)
Government Program: HRSA

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

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

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

regarding MACs' oversight of hospice cap calculations.

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

HCPCS Codes Identified in This Audit:

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

Audit #: A-02-20-01001 (09/23/2022)
Government Program: CMS

Medicare Hospice Provider Compliance Audit: Vitas Healthcare Corporation of Florida

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

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

The audit covered 50,850 claims for which Vitas received Medicare reimbursement totaling $210 million for certain hospice services provided during the period April 2017 through March 2019. OIG reviewed and evaluated a stratified sample of 100 claims for compliance with selected Medicare requirements. In addition, OIG submitted medical records

associated with the sample to an independent medical review contractor who determined whether the documents supported the hospice services billed.

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

Audit #: A-02-19-01018 (07/14/2022)
Government Program: CMS

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

operating consistent with its longstanding position that services unrelated to a hospice beneficiary's terminal illness and related conditions should have been exceptional, unusual, and rare given the comprehensive nature of the services covered under the Medicare hospice benefit.

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

Audit #: A-09-20-03015 (02/14/2022)
Government Program: CMS

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Medical Equipment and Supplies

[NEW] Medicare Improperly Paid Suppliers for Intermittent Urinary Catheters

- From 2014 through 2021, CMS identified high improper payments for urological supplies, which included intermittent urinary catheters (catheters).
- Because of the ongoing risk of improper payments, OIG conducted this nationwide audit to determine whether Medicare paid suppliers for catheters in accordance with Medicare requirements for catheters provided to enrollees from July 2021 through June 2022 (audit period).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare did not make some payments to suppliers for catheters in accordance with Medicare requirements:

- Payments for 88 of 105 sample items met requirements. (OIG did not review 2 of 105 sample items and treated them as non-errors because after OIG had selected the sample, it was determined that Medicare contractors had denied the claims.)
- Payments for the remaining 15 sample items did not meet requirements. Specifically, medical records did not support Medicare enrollees' eligibility for curved-tip catheters or sterile catheter kits (kits), or suppliers did not meet Medicare requirements for catheter refills, proof of delivery, or a standard written order.

  On the basis of the sample results, OIG estimated that of the $303.3 million Medicare paid for catheters and kits for the audit period, approximately $35.1 million was improperly paid. In addition, OIG estimated that enrollees were responsible for approximately $8.8 million in associated coinsurance.

  In addition, OIG's analysis of Medicare claims submitted after the audit period showed that suppliers billed 125,426 claims for curved-tip catheters provided to female enrollees in 2023, compared with 2,753 claims for the audit period. This large increase in claims billed may have been an indication of improper claims. OIG shared the analysis, identifying suppliers with questionable billing patterns, with CMS so that it could take action as needed. In comments on the draft report, CMS informed OIG that it had already taken corrective action on 15 suppliers.

OIG recommended that CMS instruct Medicare contractors to recover $11,399 in overpayments made to suppliers for the 15 sample items that did not meet Medicare requirements; perform additional medical reviews of claims for catheters and kits, which could have saved Medicare an estimated $35.1 million for the audit period; and provide additional education to suppliers on documenting eligibility for curved-tip catheters and kits and on documenting refills of catheters and kits. The full recommendations were in the report.

HCPCS Codes Identified in This Audit:

- A4351 - Straight-tip catheter
- A4352 - Curved-tip catheter (also called a Coude-tip catheter)
- A4353 - Sterile catheter kit, which includes a straight-tip or curved-tip catheter with all necessary insertion supplies.

Audit #: A-09-22-03019 (02/04/2025)
Government Program: CMS

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

HCPCS Codes Identified in This Audit:

- L1832 - Off-the-shelf knee brace

Audit #: A-09-21-03019 (05/24/2024)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

The report contained one other recommendation.

HCPCS Codes Identified in This Audit:

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

Audit #: A-09-22-03003 (07/31/2023)
Government Program: CMS

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

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

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

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

HCPCS Codes Identified in This Evaluation:

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

Evaluation #: OEI-04-20-00620 (08/30/2022)
Government Program: CMS

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

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

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

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

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

charges for 922 PMD repairs totaling $170,776.

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

HCPCS Codes Identified in This Audit:

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

Audit #: A-09-20-03016 (05/31/2022)
Government Program: CMS

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Provider

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

Behavioral Health

[NEW] Mental Health Center of Florida Generally Met Medicare Billing Requirements for Some Psychotherapy Services

- During calendar year 2019, Medicare Part B paid approximately $1 billion for psychotherapy services.
- Prior Office of Inspector General (OIG) audits of psychotherapy providers identified a high number of improper payments and found that providers did not always comply with Medicare billing requirements.
- This audit examined whether Mental Health Center of Florida (MHCF) complied with Medicare requirements when billing for psychotherapy services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that:

- For 1 of 100 sampled claim lines, MHCF billed an incorrect Current Procedural Terminology (CPT) code. The error occurred because the provider inadvertently billed the incorrect CPT code.
- Since the audit period ended, MHCF stated that it updated its internal controls, including additional quality assurance steps, to increase compliance with Medicare requirements.

OIG recommended that Mental Health Center of Florida monitor and evaluate the effectiveness of its quality assurance program updates to ensure that documenting of time spent on psychotherapy services met Medicare requirements.

CPT Codes Identified in This Audit:

- 90837 - Psychotherapy for 60 minutes
- 90834 - Psychotherapy for 45 minutes
- 90832 - Psychotherapy for 30 minutes
- 90833 - Psychotherapy for 30 minutes with E&M;
- 90836 - Psychotherapy for 45 minutes with E&M;
- 90838 - Psychotherapy for 60 minutes with E&M;
- 90853 - Group Psychotherapy
- 90785 - Interactive Complexity

Audit #: A-04-21-06251 (02/19/2025)
Government Program: CMS

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

1. Take steps to encourage more behavioral health providers to serve Medicare and Medicaid enrollees.

2. Explore options to expand Medicare and Medicaid coverage to additional behavioral health providers.

3. Use network adequacy standards to drive an increase in behavioral health providers in Medicare Advantage and Medicaid.

4. Increase monitoring of Medicare and Medicaid enrollees' use of behavioral health services and identify vulnerabilities.

CPT Codes Identified in This Evaluation:

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

Evaluation #: OEI-02-22-00050 (03/29/2024)
Government Program: CMS

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

OIG recommended that CMS:

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

The report contained three other recommendations.

CPT Codes Identified in This Audit:

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

Audit #: A-09-21-03021 (05/02/2023)
Government Program: CMS

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

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

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

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

signed by the treating physician.

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

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

CPT Codes Identified in This Audit:

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

Audit #: A-02-21-01006 (03/29/2022)
Government Program: CMS

SUNHAWK CONSULTING

Provider

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

Laboratory

[NEW] Total Medicare Part B Spending on Lab Tests Decreased in 2023, Driven in Part by Less Spending on COVID-19 Tests

This review was part of an effort to help control Medicare lab test spending. The Protecting Access to Medicare Act of 2014 required that Medicare Part B payment rates align with rates paid by private payors. To provide oversight that these efforts were helping to control lab test spending, Congress also mandated that OIG publicly release an annual analysis of the top 25 tests based on Medicare spending and conduct analyses that OIG determined appropriate. This data snapshot provided an analysis of Medicare Part B payments for lab tests in 2023, including an analysis of the top 25 tests. From 2018 through 2020, CMS implemented new Medicare Part B lab test payment rates. In 2021, new payment rates were to go into effect; however, changes in legislation delayed any rate changes. The next payment rate changes were scheduled for January 1, 2027.

OIG analyzed Medicare Part B claims data for lab tests paid for under the Medicare Clinical Laboratory Fee Schedule in 2023. OIG identified key statistics and trends for total Medicare Part B spending on lab tests, including the top 25 lab tests on the basis of total spending.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- In 2023, total Medicare Part B spending on clinical diagnostic laboratory tests (lab tests) decreased by 5.4 percent from total lab test spending in 2022.
- Spending on COVID-19 tests decreased significantly in 2023 due to several factors, including the widespread availability of over-the-counter COVID-19 tests.
- Medicare Part B spending on genetic tests has steadily increased over the last 10 years.

OIG concluded that this data snapshot contained no recommendations.

CPT Codes Identified in This Evaluation:

- 81528 - Genetic test: Gene analysis (colorectal cancer)
- 87798 - Detection test by nucleic acid for organism, amplified probe technique
- 85025 - Complete blood cell count (red cells, white blood cells, platelets), automated
- 82306 - Vitamin D-3 level
- 83036 - Hemoglobin A1C level
- 81455 - Genetic test: Test for detecting genes associated with cancer
- 80307 - Testing for presence of drug, by chemistry analyzers
- 0242U - Genetic test: Gene analysis of 55-74 genes associated with solid organ cancer in cell-free
- 87637 - COVID-19 test: Detection test by multiplex amplified probe technique for severe acute
- 83970 - Parathormone (parathyroid hormone) level
- 81519 - Genetic test: Test for detecting genes associated with breast cancer
- 82607 - Cyanocobalamin (vitamin B-12) level
- 0241U - COVID-19 test: Respiratory infectious agent detection by RNA for severe acute respiratory
- 80048 - Blood test, basic group of blood chemicals (calcium, total)

- 87635 - COVID-19 test: Amplified DNA or RNA probe detection of severe acute respiratory syndrome
- 84153 - PSA (prostate specific antigen) measurement, total
- 81542 - Genetic test: mRNA gene expression analysis of 22 genes in prostate tumor tissue
- 80053 - Blood test, comprehensive group of blood chemicals
- 80061 - Blood test, lipids (cholesterol and triglycerides)
- 84443 - Blood test, thyroid stimulating hormone (TSH).

HCPCS Codes Identified in This Evaluation:

- G0483 - Drug test(s), definitive, 22 or more drug class(es)
- U0003 - COVID-19 test: Infectious agent detection by nucleic acid (DNA or RNA); severe acute
- G0482 - Drug test(s), definitive, 15-21 drug class(es)
- G0480 - Drug test(s), definitive, 1-7 drug class(es)
- G0481 - Drug test(s), definitive, 8-14 drug class(es).

Evaluation #: OEI-09-24-00350 (12/20/2024)
Government Program: CMS

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

HCPCS Codes Identified in This Audit:

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

Audit #: A-09-22-03015 (05/08/2024)
Government Program: CMS

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

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

CPT Codes Identified in This Audit:

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

HCPCS Codes Identified in This Audit:

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

Audit #: A-01-21-00506 (04/03/2024)
Government Program: CMS

Medicare Part B Spending on Clinical Diagnostic Laboratory Tests in 2022

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

CPT Codes Identified in This Evaluation:

- 87798 - Detection test by nucleic acid for organism
- 83036 - Hemoglobin A1C level
- 83970 - Parathormone (parathyroid hormone) level
- 80307 - Testing for presence of drug, by chemistry analyzers
- 87635 - COVID-19 test: Amplified DNA or RNA probe detection of severe acute respiratory syndrome
- 87426 - COVID-19 test: Detection test by immunoassay technique for severe acute respiratory syndrome

- 81519 - Genetic test: Test for detecting genes associated with breast cancer
- 81455 - Genetic test: Test for detecting genes associated with cancer
- 82607 - Cyanocobalamin (vitamin B-12) level
- 80048 - Blood test, basic group of blood chemicals (Calcium, total)
- 84153 - PSA (prostate specific antigen) measurement, total.

HCPCS Codes Identified in This Evaluation:

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

Evaluation #: OEI-09-23-00350 (12/19/2023)
Government Program: CMS

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

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

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

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

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

OIG recommended that CMS direct the appropriate Medicare contractors to:

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

The report contained one other recommendation.

CPT Codes Identified in This Audit:

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

ICD Codes Identified in This Audit:

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

Audit #: A-09-22-03010 (06/21/2023)
Government Program: CMS

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

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

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

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

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

SunHawk Summary of OIG Audit Findings and Recommendations

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

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

OIG recommended that CMS:

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

CPT Codes Identified in This Audit:

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

HCPCS Codes Identified in This Audit:

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

ICD Codes Identified in This Audit:

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

Audit #: A-09-21-03006 (02/27/2023)
Government Program: CMS

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

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

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

SunHawk Summary of OIG Evaluation Findings and Recommendations

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

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

Medicare Part B spending on non-COVID-19 tests also increased. Total spending on four categories of high-priced genetic tests increased by 56 percent, from $1.2 billion in 2020 to $1.9 billion in 2021, exceeding pre-pandemic spending levels. Spending on chemistry tests--the largest category of tests by both spending and volume--increased from $1.9 billion in 2020 to $2.1 billion, but remained below pre-pandemic levels.

Medicare Part B spent $5.5 billion in 2021 on the top 25 tests, which accounted for 59 percent of total test spending. The factors that affected overall spending also contributed to the increase in spending on the top 25 tests. These factors were the increased volume for COVID-19 tests, the continued growth of high-priced genetic tests, and the increased volume for panel and chemistry tests.

OIG concluded that the COVID-19 pandemic continued to have an impact on Medicare Part B spending on lab tests. Spending on COVID-19 tests increased in 2021, driven by more people receiving more tests. However, the decline between pre-pandemic levels for chemistry tests and the 2020 and 2021 levels could indicate that people were not seeking the routine or preventive care appointments where these tests were ordered. The second year in a row of low volume for chemistry tests raised questions about the pandemic's long-term impact on Medicare enrollee health.

CPT Codes Identified in This Evaluation:

- 80053 - Blood test, comprehensive group of blood chemicals
- 80061 - Blood test, lipids
- 84443 - Blood test, thyroid stimulating hormone
- 85025 - Complete blood cell count, automated test
- 81408 - Genetic test: Molecular pathology procedure level 9
- 82306 - Vitamin D-3 level
- 81528 - Genetic test: Gene analysis (colorectal cancer)
- 87798 - Detection test for organism
- 83036 - Hemoglobin A1C level
- 80307 - Testing for presence of drug
- 87635 - COVID-19 test: Amplified probe technique
- 87426 - COVID-19 test: ELISA detection of severe acute respiratory syndrome coronavirus 2 (COVID-19)
- 83970 - Parathormone (parathyroid hormone) level
- 81162 - Genetic test: Gene analysis (breast cancer 1 and 2)
- 81519 - Genetic test: Test for detecting genes associated with breast cancer
- 80048 - Blood test, basic group of blood chemicals
- 82607 - Cyanocobalamin (vitamin B-12) level
- 81407 - Genetic test: Molecular pathology procedure level 8

HCPCS Codes Identified in This Evaluation:

- U0003 - COVID-19 test: Infectious agent detection by nucleic acid for COVID-19, high-throughput
- U0005 - COVID-19 test: Add-on payment for high throughput tests completed within 2 calendar days of specimen collection
- U0004 - COVID-19 test: Any technique, high-throughput technologies
- G0483 - Drug test(s), definitive, 22 or more drug class(es)

- G0482 - Drug test(s), definitive, 15-21 drug class(es)
- G0480 - Drug test(s), definitive, 1-7 drug class(es)
- G0481 - Drug test(s), definitive, 8-14 drug class(es)

Evaluation #: OEI-09-22-00400 (12/19/2022)
Government Program: CMS

Labs With Questionably High Billing for Additional Tests Alongside COVID-19 Tests Warrant Further Scrutiny

Medicare Part B spending on COVID-19 lab tests increased steadily between spring 2020--when Medicare first started paying for these tests--and the end of that year. Preliminary analysis of Medicare Part B claims data indicated that some diagnostic testing laboratories billed for other diagnostic tests--such as individual respiratory tests (IRTs), respiratory pathogen panels (RPPs), genetic tests, and allergy tests--along with COVID-19 tests. OIG referred to these four types of tests billed with COVID-19 tests as add-on tests. Although it was not unusual for labs to bill for COVID-19 tests and other diagnostic tests on the same claim, certain billing patterns--such as a high volume of or high payments for add-on tests--raised concerns of potential waste or fraud.

OIG performed outlier analysis to identify labs that billed for add-on tests at questionably high levels compared to other labs that billed for COVID-19 tests. OIG identified two kinds of outlier labs: (1) those for which add-on tests constituted a high proportion of each lab's total *number* of tests, and (2) those for which add-on tests constituted a high proportion of each lab's total *payments* for tests.

OIG examined all Medicare Part B claims paid for COVID-19 tests during 2020, and for the following types of add-on tests: IRTs, RPPs, genetic tests, and allergy tests.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that 378 labs billed Medicare Part B for add-on tests at questionably high levels--in volume, payment amount, or both--compared to the 19,199 other labs. This included 276 labs that billed for high volumes of add-on tests on claims for COVID-19 tests, and 263 labs that billed for high payment amounts from add-on tests on claims for COVID-19 tests. Further, 161 of these labs billed for both high volumes of add-ons and high payment amounts from add-ons on claims for COVID-19 tests. OIG also found a small number of labs that had at least 10 claims where 2 labs had billed for the same enrollee for the same tests on the same day, which may have been an indication of a fraud scheme involving the sharing of enrollee information.

On their claims for COVID-19 tests, some of the 378 labs billed for add-on tests in combinations that had little if any variation across patients. This may have indicated that these tests were not specific to individual patients' needs. The add-on tests significantly increased the per-claim amounts that Medicare Part B paid to these labs. For example, one outlier lab regularly billed for a combination of five add-on respiratory tests on almost all of its claims for COVID-19 tests. As a result, the average per-claim Medicare payment to this outlier lab was $666, covering both COVID-19 and add-on tests, compared to an average payment of $89 to all other labs that billed for COVID-19 tests and any add-on tests. Although billing for add-on tests was generally allowable, and Medicare Part B pays for these tests when they are medically appropriate, these patterns of questionably high billing raised concerns that some tests may have been

wasteful or potentially fraudulent.

OIG concluded that further scrutiny of billing by the 378 outlier labs was needed and, therefore, the Office of Inspector General referred these labs to the Centers for Medicare & Medicaid Services for further review. Outlier labs exceeded the thresholds for one or both measures of questionable billing, raising concerns about potential waste or fraud.

CPT Codes Identified in This Evaluation:

- 87798 - Detection test by nucleic acid for organism, amplified probe technique. This is a general test code that is used when a specific code is not available, and can be used to indicate tests for measles, mumps, norovirus among others
- 87581 - Detection test by nucleic acid for Mycoplasma pneumoniae (bacteria), amplified probe technique
- 87486 - Detection test by nucleic acid for Chlamydia pneumoniae, amplified probe technique
- 87631 - Detection test by nucleic acid for multiple types of respiratory virus, multiple types or subtypes, 3-5 targets
- 87633 - Detection test by nucleic acid for multiple types of respiratory virus, multiple types or subtypes, 12-25 targets

Evaluation #: OEI-09-20-00510 (12/06/2022)
Government Program: CMS

The Number of Beneficiaries Who Received Medicare Part B Clinical Laboratory Tests Decreased During the First 10 Months of the COVID-19 Pandemic

Clinical laboratory (lab) tests, when used appropriately, were important because they provided health care providers with information to prevent, detect, diagnose, treat, and manage disease (including managing chronic medical conditions). These conditions had health impacts and economic costs, and prevention could reduce costs. To help contain the spread of COVID-19, Federal, State, Tribal, and local government agencies implemented community mitigation activities, including some issuing orders or advisories to residents to stay at home. These and other factors may have contributed to Medicare beneficiaries receiving fewer clinical services, including lab tests. OIG's preliminary analysis of lab tests billed to and paid by Medicare Part B found decreases in the number of beneficiaries who received lab tests when compared with a similar period before the pandemic.

OIG's objective was to identify changes in the number of beneficiaries who received Medicare Part B lab tests during the first 10 months of the COVID-19 pandemic—specifically, the number of beneficiaries who received: (1) all lab tests and (2) lab tests associated with certain chronic medical conditions (i.e., diabetes, kidney disease, and heart disease) common among Medicare beneficiaries.

OIG's audit covered Part B claims for lab tests provided from March through December 2019 ('pre-pandemic period') and from March through December 2020 ('pandemic period').

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that during the pandemic period, the number of beneficiaries who received Medicare Part B lab tests decreased for: (1) all lab tests and (2) lab tests associated with certain chronic medical conditions (i.e., diabetes, kidney disease, and heart disease) common among Medicare beneficiaries. From March through December in 2016, 2017, and 2018 and for the pre-pandemic period (in 2019), the number of beneficiaries who received lab tests paid for by Medicare

decreased by 1 percent or less in each year. However, for the pandemic period (in 2020), the number of beneficiaries who received lab tests decreased by about 9 percent compared with the pre-pandemic period.

OIG's comparison of the numbers of beneficiaries who received lab tests during the pandemic and pre-pandemic periods identified the following trends: (1) The number of beneficiaries who received lab tests had the highest percentage decreases during the first 3 months of the pandemic period when compared with the same months during the pre-pandemic period; (2) for almost 90 percent of lab tests for which the number of tests performed had decreased during the pandemic period, the number of beneficiaries who received those tests decreased by more than 10 percent; (3) for the gender and residential location (i.e., rural or urban) demographics, during the pandemic period the number of beneficiaries who received lab tests had similar percentage decreases for each category within the corresponding demographic (e.g., the female and male genders had similar percentage decreases); (4) for the race or ethnicity group demographic, during the pandemic period there was more variation in the percentage decreases in the number of beneficiaries who received lab tests for each category (e.g., the Hispanic or Latino category had a higher percentage decrease than the White category); and (5) the number of beneficiaries with diabetes, kidney disease, and heart disease who received common lab tests for those conditions decreased during the pandemic period. The results of OIG's data analysis suggested that the COVID-19 pandemic contributed to these decreases. Lab tests are important for beneficiaries with chronic medical conditions, which are associated with hospitalizations, billions of dollars in Medicare costs, and deaths.

OIG concluded that the information in this report was provided for informational purposes only and therefore the report did not contain any recommendations.

CPT Codes Identified in This Audit:

- 83036 - Hemoglobin A1C level
- 80053 - Blood test, comprehensive group of blood chemicals
- 80061 - Blood test, lipids (cholesterol and triglycerides)
- 85025 - Complete blood cell count (red cells, white blood cell, platelets), automated test
- 82043 - Urine microalbumin (protein) level
- 84443 - Blood test, thyroid stimulating hormone (TSH)
- 82570 - Creatinine level to test for kidney function or muscle injury
- 87186 - Evaluation of antimicrobial drug (antibiotic, antifungal, antiviral)
- 82746 - Folic acid level
- 81002 - Urinalysis, manual test
- 83550 - Iron binding capacity

HCPCS Codes Identified in This Audit:

- G0103 - Prostate cancer screening; prostate specific antigen test (psa)

ICD Codes Identified in This Audit:

- E11 - Type 2 Diabetes Mellitus
- N18 - Chronic Kidney Disease (Ckd)
- I25 - Chronic Ischemic Heart Disease

Provider

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

Audit #: A-09-21-03004 (11/09/2022)
Government Program: CMS

Telehealth

Additional Oversight of Remote Patient Monitoring in Medicare Is Needed

- Medicare broadly covered remote patient monitoring of health data for any chronic or acute condition.
- The use of remote patient monitoring had the potential to greatly expand in the Medicare population.
- As a result, there was an increasing need to know how remote patient monitoring was being used, including who was receiving it and for what conditions, as well as a need to identify any vulnerabilities that might limit the oversight of these services.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that:

- The use of remote patient monitoring in Medicare increased dramatically from 2019 to 2022.
- About 43 percent of enrollees who received remote patient monitoring did not receive all 3 components of it, raising questions about whether the monitoring was being used as intended.
- OIG and CMS had raised concerns about fraud related to remote patient monitoring.
- Medicare lacked key information for oversight, including who ordered the monitoring for the enrollee.

  Taken together, OIG's findings demonstrated the need for additional oversight to ensure that remote patient monitoring was being used and billed appropriately.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) take the following steps to strengthen oversight of remote patient monitoring:

1. Implement additional safeguards to ensure that remote patient monitoring was used and billed appropriately in Medicare.
2. Require that remote patient monitoring be ordered and that information about the ordering provider be included on claims and encounter data for remote patient monitoring.
3. Develop methods to identify what health data were being monitored.
4. Conduct provider education about billing of remote patient monitoring.
5. Identify and monitor companies that billed for remote patient monitoring.

CPT Codes Identified in This Evaluation:

- 99091 - Treatment management service that includes time for providers to communicate with patients about their data and related treatment decisions
- 99453 - Education and setup of remote patient monitoring
- 99454 - Device supply for remote patient monitoring
- 99457 - Remote patient monitoring treatment management services
- 99458 - Additional treatment management services for remote patient monitoring

Evaluation #: OEI-02-23-00260 (09/19/2024)
Government Program: CMS

Medicare Generally Paid for Evaluation and Management Services Provided via Telehealth During the First 9 Months of the COVID-19 Public Health Emergency That Met Medicare Requirements

In response to the COVID-19 public health emergency (PHE), CMS temporarily expanded access to health services provided via telehealth. From March 2020 through November 2020 (audit period), Medicare Part B paid approximately $10.3 billion for Evaluation and Management (E/M) services, including telehealth services, provided to Medicare enrollees nationwide. The telehealth expansion increased the risk of inappropriate payments in the Medicare program due to the extent and speed of the changes. Therefore, CMS's oversight of the telehealth expansion became increasingly important to ensure that enrollees received the appropriate quality of care both during and after the PHE, while protecting the Medicare program from fraud, waste, and abuse.

OIG's objective was to determine whether physicians and other practitioners that provided E/M services via telehealth complied with Medicare requirements.

OIG's audit covered $1.4 billion in Medicare Part B payments for more than 19 million E/M claim line services that were billed with place of service codes or modifiers indicating telehealth was used to provide the service during the audit period. OIG selected a stratified random sample containing three strata of E/M services provided via telehealth during the audit period. One stratum included 30 E/M services billed as telehealth services provided to new patients and the other two strata each included 40 E/M services billed as telehealth services provided to established patients.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that physicians and other practitioners that provided E/M services via telehealth generally complied with Medicare requirements. For 105 of the 110 sampled E/M services provided via telehealth, providers complied with Medicare requirements. However, for the remaining five sampled E/M services, providers did not comply with Medicare requirements. Medicare paid $446 for the five sampled E/M services for which providers did not document or insufficiently documented the services. OIG also identified potential documentation issues in the medical records used to support the sampled E/M services that OIG discussed in the Other Matters section of this report.

This report did not have recommendations because providers generally met Medicare requirements when billing for E/M services provided via telehealth and unallowable payments OIG identified resulted primarily from clerical errors or the inability to access records.

CMS elected not to provide comments on OIG's draft report.

CPT Codes Identified in This Audit:

- 99213 - Established patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of low to moderate severity. Typically, 15 minutes are spent face-to-face with the patient and/or family.
- 99214 - Established patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

- 99215 - Established patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
- 99201 - New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family.
- 99202 - New patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are of low to moderate severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.
- 99203 - New patient office or other outpatient visit. Medical decision making of low complexity. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.
- 99204 - New patient office or other outpatient visit. Medical decision making of moderate complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 45 minutes are spent face-to-face with the patient and/or family.
- 99205 - New patient office or other outpatient visit. Medical decision making of high complexity. Usually, the presenting problem(s) are of moderate to high severity. Typically, 60 minutes are spent face-to-face with the patient and/or family.
- 99211 - Established patient office or other outpatient visit. Usually, the presenting problem(s) are minimal. Typically, 5 minutes are spent performing or supervising these services.
- 99212 - Established patient office or other outpatient visit. Straightforward medical decision making. Usually, the presenting problem(s) are self-limited or minor. Typically, 10 minutes are spent face-to-face with the patient and/or family

Audit #: A-01-21-00501 (02/13/2024)
Government Program: CMS

Telehealth During 2020 Helped Ensure End-Stage Renal Disease Patients Received Care, But Limited Information Related to Telehealth Was Documented

In response to the COVID-19 public health emergency (PHE) and pursuant to section 1135 of the Social Security Act, the Secretary of Health and Human Services (HHS) authorized the Centers for Medicare & Medicaid Services (CMS) to temporarily implement waivers and modifications to Medicare program requirements, retroactive to March 2020. From March through December 2020 (audit period), Medicare claims data showed that payments for end-stage renal disease (ESRD)-related telehealth services increased almost 10,000 percent from 2019. Oversight of telehealth expansion was increasingly important to ensure that Medicare enrollees received the appropriate care while protecting the program from fraud, waste, and abuse. OIG conducted this audit of ESRD-related telehealth services provided during the first year of the PHE to verify whether providers complied with Medicare requirements, determine what telehealth-related information was documented in the medical records, and further inform policymakers and other stakeholders as they considered permanent changes to telehealth policies.

OIG's objectives were to determine, for ESRD-related telehealth services provided during the PHE: (1) what information related to the telehealth services was documented in the medical records and (2) whether the claims met certain Medicare requirements.

OIG's audit covered approximately $38 million in Medicare Part B payments for 179,952 ESRD-related telehealth services provided during the audit period. OIG selected a stratified random sample: one stratum included 75 claim lines for telehealth services provided to in-center dialysis patients, and the other included 25 claim lines for telehealth services provided to at-home dialysis patients.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that providers documented limited information related to telehealth services in the medical records, but the ESRD-related telehealth service claim lines generally met certain Medicare requirements. Most medical records for sampled claim lines included documentation identifying that the service was provided via telehealth but did not include documentation that would allow OIG to determine whether the services were provided using 1) audiovisual interactive technology and 2) technology that was non-public-facing.

OIG found that CMS did not oversee or enforce whether the telecommunications systems used to provide telehealth services were non-public-facing; the Health and Human Service's Office for Civil Rights (OCR) had responsibility for oversight of this requirement. Any information in this report regarding non-public-facing telecommunications systems used was for informational purposes only.

OIG concluded that it would be beneficial for the medical records to document the type of telecommunications system used to perform the telehealth visit. This information may be beneficial to CMS and OCR when considering future oversight mechanisms or changes regarding remote communication products.

CPT Codes Identified in This Audit:

- 90951 - Age-specific and based on the number of visits per month for patients receiving dialysis in an outpatient setting (in-center)
- 90962 - Age-specific and based on the number of visits per month for patients receiving dialysis in an outpatient setting (in-center)
- 90963 - Age-specific and based on the number of visits per month for patients receiving dialysis at home
- 90966 - Age-specific and based on the number of visits per month for patients receiving dialysis at home
- 90967 - Age-specific and based on the number of visits for less than a month of service, billed per day
- 90970 - Age-specific and based on the number of visits for less than a month of service, billed per day

Audit #: A-05-22-00015 (08/01/2023)
Government Program: CMS

The IHS Telehealth System Was Deployed Without Some Required Cybersecurity Controls

In response to the COVID-19 pandemic, health care providers increasingly delivered care using telehealth technologies. These technologies improved access to care, increased patient convenience, and increased service-delivery efficiency.

OIG's objective was to determine whether the Indian Health Service (IHS) implemented select cybersecurity controls to protect its telehealth system.

OIG reviewed applicable IHS and HHS policies and procedures for telehealth technologies, interviewed staff, and reviewed system security documentation to determine whether IHS telehealth technologies were secure. OIG focused on determining whether IHS designed and implemented cybersecurity controls that were essential to securing IHS telehealth systems components before deployment.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that although IHS deployed a national telehealth system, which increased the availability of health care services during the pandemic, it did not complete select IT controls as required prior to deploying its telehealth system nationally. Specifically, IHS did not complete the contingency plan, risk assessment, finalized authorization to operate (ATO), and system security plan. Additionally, after deployment of the telehealth system, IHS did not remediate known vulnerabilities on some telehealth system devices in a timely manner.

OIG recommended that the Indian Health Service develop a strategy for identifying, implementing, and testing cybersecurity controls for new information systems that were deployed in an expedited fashion to meet an urgent, mission-critical need. The strategy should have defined the minimum set of critical controls that must be implemented and tested before the system was deployed, noting the acceptance of risk for not implementing all required controls and stipulating that the full ATO process would be completed within a specific time period. OIG also recommended that the Indian Health Service ensure that adequate policies, procedures, and training were implemented to ensure that known telehealth vulnerabilities were remediated in a timely manner.

Audit #: A-18-21-03100 (09/07/2022)
Government Program: IHS

Certain Medicare Beneficiaries, Such as Urban and Hispanic Beneficiaries, Were More Likely Than Others To Use Telehealth During the First Year of the COVID-19 Pandemic

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, the Department of Health and Human Services (HHS) and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. CMS allowed beneficiaries to use telehealth for a wide range of services and in different locations, including in urban areas and from the beneficiary's home.

In a companion report, OIG found that the use of telehealth increased dramatically during the first year of the pandemic. More than 28 million--about 2 in 5--Medicare beneficiaries used telehealth that first year. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

This data brief expanded on that analysis and examined the characteristics of beneficiaries who used telehealth during the first year of the pandemic. This information shed light on how the temporary expansion of telehealth affected different groups of beneficiaries. This information would help CMS, HHS, Congress, and other stakeholders understand who benefited from the expansion and make decisions about whether some of the temporary changes should become permanent. It could also inform efforts aimed at ensuring that all beneficiaries had appropriate access to telehealth.

This data brief included beneficiaries in Medicare fee-for-service and Medicare Advantage. This report was part of a

series that examined the use of telehealth in Medicare and identified program integrity concerns related to telehealth during the pandemic.

This analysis focused on Medicare beneficiaries who used telehealth services during the first year of the pandemic, from March 1, 2020, to February 28, 2021. OIG based this analysis on Medicare fee-for-service claims data, Medicare Advantage encounter data, and data from the Medicare Enrollment Database.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that beneficiaries in urban areas were more likely than those in rural areas to use telehealth during the first year of the pandemic. Beneficiaries in Massachusetts, Delaware, and California were more likely than beneficiaries in some other States to use telehealth. Dually eligible beneficiaries (i.e., those eligible for both Medicare and Medicaid), Hispanic beneficiaries, younger beneficiaries, and female beneficiaries were also more likely than others to use telehealth. In addition, beneficiaries almost always used telehealth from home or other non-health-care settings. Furthermore, almost one-fifth of beneficiaries used certain audio-only telehealth services, with the vast majority of these beneficiaries using these audio-only services exclusively. Older beneficiaries were more likely to use these audio-only services, as were dually eligible and Hispanic beneficiaries.

OIG recommended that CMS: (1) take appropriate steps to enable a successful transition from current pandemic-related flexibilities to well-considered long-term policies for the use of telehealth for beneficiaries in urban areas and from the beneficiary's home, (2) temporarily extend the use of audio-only telehealth services and evaluate their impact, (3) require a modifier to identify all audio-only telehealth services provided in Medicare, and (4) use telehealth to advance health care equity.

CPT Codes Identified in This Evaluation:

- 99441 - Telephone evaluation and management service, 5-10 minutes of medical discussion
- 99442 - Telephone evaluation and management service, 11-20 minutes of medical discussion
- 99443 - Telephone evaluation and management service, 21-30 minutes of medical discussion
- 98966 - Telephone assessment and management service, 5-10 minutes of medical discussion
- 98967 - Telephone assessment and management service, 11-20 minutes of medical discussion
- 98968 - Telephone assessment and management service, 21-30 minutes of medical discussion

Evaluation #: OEI-02-20-00522 (08/29/2022)
Government Program: CMS

Medicare Telehealth Services During the First Year of the Pandemic: Program Integrity Risks

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, the Department of Health and Human Services (HHS) and CMS took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. In addition, CMS temporarily paused several program integrity activities, including medical reviews of claims.

In a related report, the OIG found that the use of telehealth increased dramatically during the first year of the pandemic. More than 28 million Medicare beneficiaries--about 2 in 5--used telehealth services that first year. In total, beneficiaries

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Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

used 88 times more telehealth services during the first year of the pandemic than they did in the prior year.

The changes to Medicare telehealth policies, along with the dramatic increase in the use of telehealth, underscored the importance of determining whether providers were billing for telehealth services appropriately and how to best protect Medicare and beneficiaries against fraud, waste, and abuse.

This data brief described providers' billing for telehealth services and identified ways to safeguard Medicare from fraud, waste, and abuse related to telehealth. This information could help CMS, Congress, and other stakeholders determine what safeguards might be needed as they considered permanent changes to telehealth policies in Medicare.

This report was part of a series that examined the use of telehealth in Medicare and the characteristics of beneficiaries who used telehealth during the pandemic.

This data brief was based on an analysis of Medicare fee-for-service claims data and Medicare Advantage encounter data for the first year of the pandemic from March 1, 2020, to February 28, 2021. OIG focused the analysis on the approximately 742,000 providers who billed for a telehealth service. Using input from OIG investigators, OIG developed seven measures that focused on different types of billing for telehealth services that may indicate fraud, waste, or abuse. For each of these measures, OIG set very high thresholds to identify providers whose billing posed a high risk to Medicare. Because this data brief focused on specific measures with very high thresholds, it did not capture all concerning billing related to telehealth services that may have been occurring in Medicare. Additionally, this report did not confirm that any particular provider was engaging in fraudulent or abusive practices. Any determination of fraud or an overpayment would have required additional investigation.

Further, a Medicare billing practice—known as "incident to" billing—created challenges for oversight because it allowed services provided by clinical staff who were directly supervised by a practitioner to be billed under the supervising practitioner's identification number. It was critical for program integrity efforts to identify the individual who delivered the telehealth service that was billed to Medicare. To address these limitations in the data, OIG developed measures for this report that aimed to minimize the effect of "incident to" billing on the results of the claims analysis.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that 1,714 providers whose billing for telehealth services during the first year of the pandemic posed a high risk to Medicare. These providers billed for telehealth services for about half a million beneficiaries and received a total of $127.7 million in Medicare fee-for-service payments.

Each of these 1,714 providers had concerning billing on at least 1 of 7 measures OIG developed that may indicate fraud, waste, or abuse of telehealth services. All of these providers warranted further scrutiny. For example, they may have been billing for telehealth services that were not medically necessary or were never provided.

In addition, more than half of the high-risk providers OIG identified were a part of a medical practice with at least one other provider whose billing posed a high risk to Medicare. This may have indicated that certain practices were encouraging such billing among their associated providers. Further, 41 providers whose billing posed a high risk appeared to be associated with telehealth companies; however, there was currently no systematic way to identify these companies in the Medicare data.

OIG concluded that although these high-risk providers represented a small proportion of all providers who billed for a telehealth service, these findings demonstrated the importance of strong, targeted oversight of telehealth services. The findings also offered insight on how Medicare and others could protect beneficiaries against fraud, waste, and abuse. Conducting targeted oversight of telehealth would help ensure the benefits of telehealth were realized while minimizing risk in an effective and efficient manner. Accordingly, OIG recommended that CMS:

- strengthen monitoring and targeted oversight of telehealth services,
- provide additional education to providers on appropriate billing for telehealth services,
- improve the transparency of "incident to" services when clinical staff primarily delivered the telehealth service,
- identify telehealth companies that billed Medicare, and
- follow up on the providers identified in this report.

CPT Codes Identified in This Evaluation:

- 99304 - Initial nursing facility visit, typically 25 minutes
- 99307 - Subsequent nursing facility visit, typically 10 minutes
- 99318 - Evaluation and management of a patient involving an annual nursing facility assessment

Evaluation #: OEI-02-20-00720 (08/29/2022)
Government Program: CMS

Telehealth Was Critical for Providing Services to Medicare Beneficiaries During the First Year of the COVID-19 Pandemic

The COVID-19 pandemic created unprecedented challenges for how Medicare beneficiaries accessed health care. In response, the Department of Health and Human Services (HHS) and the Centers for Medicare & Medicaid Services (CMS) took a number of actions to temporarily expand access to telehealth for Medicare beneficiaries. CMS allowed beneficiaries to use telehealth for a wide range of services; it also allowed beneficiaries to use telehealth in different locations, including in urban areas and from the beneficiary's home.

This data brief provided insight into the use of telehealth in both Medicare fee-for-service and Medicare Advantage during the first year of the COVID-19 pandemic, from March 2020 through February 2021. It was a companion to a report that examined the characteristics of beneficiaries who used telehealth during the pandemic. Another report in this series identified program integrity concerns related to telehealth during the pandemic. Understanding the use of telehealth during the first year of the pandemic could shed light on how the temporary expansion of telehealth affected where and how beneficiaries accessed their health care. This information could help CMS, Congress, and other stakeholders make decisions about how telehealth could be best used to meet the needs of beneficiaries in the future.

OIG based this analysis on Medicare fee-for-service claims data and Medicare Advantage encounter data from March 1, 2020, to February 28, 2021, and from the prior year, March 1, 2019, to February 29, 2020. OIG used these data to determine the total number of services used via telehealth and in-person, as well as the types of services used. OIG also compared the number of services used via telehealth and in-person during the first year of the pandemic to those used in the prior year.

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SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that over 28 million Medicare beneficiaries used telehealth during the first year of the pandemic. This was more than 2 in 5 Medicare beneficiaries. In total, beneficiaries used 88 times more telehealth services during the first year of the pandemic than they used in the prior year. Beneficiaries' use of telehealth peaked in April 2020 and remained high through early 2021. Overall, beneficiaries used telehealth to receive 12 percent of their services during the first year of the pandemic. Beneficiaries most commonly used telehealth for office visits, which accounted for just under half of all telehealth services used during the first year of the pandemic. However, beneficiaries' use of telehealth for behavioral health services stood out. Beneficiaries used telehealth for a larger share of their behavioral health services compared to their use of telehealth for other services. Specifically, beneficiaries used telehealth for 43 percent of behavioral health services, whereas they used telehealth for 13 percent of office visits.

OIG concluded that telehealth was critical for providing services to Medicare beneficiaries during the first year of the pandemic. Beneficiaries' use of telehealth during the pandemic also demonstrated the long-term potential of telehealth to increase access to health care for beneficiaries. Further, it showed that beneficiaries particularly benefited from the ability to use telehealth for certain services, such as behavioral health services. These findings were important for CMS, Congress, and other stakeholders to take into account as they considered making changes to telehealth in Medicare. For example, CMS could use these findings to inform changes to the services that were allowed via telehealth on a permanent basis.

HCPCS Codes Identified in This Evaluation:

- GT - Modifier indicating the service was delivered via telehealth
- GQ - Modifier indicating the service was delivered via telehealth
- G0 - Modifier indicating the service was delivered via telehealth

Evaluation #: OEI-02-20-00520 (03/15/2022)
Government Program: CMS

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Other Providers and Suppliers

Massachusetts Could Better Ensure That Intermediate Care Facilities for Individuals With Intellectual Disabilities Comply With Federal Requirements for Life Safety and Emergency Preparedness

- Intermediate care facilities for individuals with intellectual disabilities (ICF/IIDs) that participated in Medicaid were required by CMS to comply with requirements intended to protect residents. This included requirements related to fire safety and emergency preparedness plans. Facilities were also required to develop infection control programs.
- In Massachusetts, the State's Department of Public Health (State agency) conducted surveys of ICF/IIDs for compliance with Federal requirements.
- This audit was the first in a series of audits that assessed compliance with CMS's life safety, emergency preparedness, and infection control requirements for ICF/IIDs.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that the State agency generally ensured that the ICF/IIDs complied with Federal requirements for infection control. However, OIG identified 44 deficiencies related to life safety and emergency preparedness at the 2 ICF/IIDs operated by Massachusetts. These deficiencies put the health and safety of residents, staff, and visitors at an increased risk of injury or death during a fire or other emergency.

OIG recommended that the State agency:
1. Follow up with the two ICF/IIDs to verify that they had taken corrective actions on the life safety and emergency preparedness deficiencies identified during the audit.
2. Work with CMS to develop standardized life safety training for ICF/IID staff.

Audit #: A-01-24-00001 (10/23/2024)
Government Program: CMS

Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements To Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers

Medicare-certified providers were required to submit an annual cost report to their Medicare administrative contractor (MAC). Cost reports were financial documents that conveyed the provider's costs associated with providing services to people enrolled in Medicare. A MAC could decide to audit a provider's cost report before bringing it to final settlement. If there was an error made in the final settlement, the MAC could reopen and adjust the cost report final settlement to correct the error.

OIG performed this audit to determine whether one MAC, Noridian Healthcare Solutions (Noridian), reopened and corrected cost report final settlements because of audit errors.

OIG's objectives were to determine: (1) how many audited cost reports Noridian reopened to correct the final settlements and (2) whether any of the audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

OIG obtained information for audited cost reports ending in fiscal years 2016 and 2017 and determined whether they had been reopened. OIG obtained workpapers, audit adjustments, and final settlement summaries. After removing cost reports that were outside of OIG's scope, OIG reviewed 12 cost reports for this audit.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Noridian reopened 141 audited cost reports to correct the final settlements. Of these, 84 cost reports were reopened based on new information or at the request of the Centers for Medicare & Medicaid Services (CMS). In addition, 45 cost reports were not related to OIG's objectives; OIG excluded these from the review. For the second objective, of the remaining 12 audited cost reports that Noridian reopened and that OIG reviewed, Noridian's audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Noridian.

These 12 cost reports required reopening because Noridian's auditors and supervisors required additional education on applicable criteria and audit requirements, because Noridian's procedures for multiple levels of review did not detect incorrect audit adjustments, and because of time constraints on Noridian's audits. The reopened cost reports resulted in revised final settlements to providers totaling almost $11.3 million in net overpayments.

OIG recommended that Noridian: (1) develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements; (2) develop and implement procedures to allow enough time for adequate auditor and supervisory review of audit documents and related actions; and (3) develop and implement enhanced procedures so that supervisors and higher-level reviewers were better qualified to detect incorrect audit adjustments.

Audit #: A-06-22-05000 (11/01/2023)
Government Program: CMS

FDA Could Take Stronger Enforcement Action Against Tobacco Retailers With Histories of Sales to Youth and Other Violations

Youth tobacco use in the United States remained a high public health concern. FDA's Tobacco Retailer Compliance Check Inspection Program was a critical part of its approach to prevent youth access to tobacco. Through that program, FDA inspected tobacco retailers to determine whether they were in violation of tobacco law or regulation. If FDA found a violation, it might issue an advisory action, such as a warning letter, or an enforcement action, such as a civil money penalty. When FDA issued an enforcement action, it had to consider mitigating factors including the nature, circumstances, extent, and gravity of the violation and, with respect to the violator, ability to pay, effect on ability to continue to do business, any history of prior such violations, and the degree of culpability.

OIG analyzed data from FDA on retailer inspections; violations; and advisory and enforcement actions from 2010 through 2019. OIG also analyzed retailer inspection and violation histories for a random sample of retailers that were subject to enforcement actions. To determine whether FDA inspection, advisory, or enforcement actions varied by neighborhood socioeconomic characteristics, OIG compared FDA inspection data to the Area Deprivation Index. OIG also interviewed FDA officials about the agency's direction and management of the retailer compliance check inspection program.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that FDA conducted more than one million inspections from 2010 through 2019, by inspecting, at least once, 74 percent of tobacco retailers that were in business nationwide as of 2020. FDA almost always returned to inspect retailers where it found violations within 12 months. In some States, inspection activities were correlated with neighborhoods' socioeconomic conditions, raising questions about how FDA and its contractors selected retailers to inspect. Overall, FDA's actions against retailers that violated tobacco laws and regulations were in accord with its policies.

However, retailers with histories of violations were often not subject to the strongest enforcement actions. FDA collected the full amount for only 9 percent of the civil money penalties (CMPs) it issued to retailers with histories of violations compared to 60 percent of CMPs it issued to retailers with fewer violations. Also, retailers in the sample that could have been subject to a no-tobacco-sale order usually did not receive one. However, OIG did not determine the extent to which FDA's consideration of mitigating factors or actions by Administrative Law Judges played a role in these outcomes.

OIG recommended that FDA (1) give greater weight to retailers' past noncompliance when taking enforcement actions against retailers with histories of violations and (2) determine whether variation in inspection activity on the basis of neighborhoods' socioeconomic status was appropriate and the extent to which it was meeting FDA's objective for protecting vulnerable populations.

Evaluation #: OEI-01-20-00240 (09/18/2023)
Government Program: FDA

Novitas Solutions, Inc., Claimed Some Unallowable Medicare Nonqualified Plan Costs Through Its Incurred Cost Proposals

The Centers for Medicare & Medicaid Services (CMS) reimbursed a portion of its contractors' nonqualified plan costs.

The Department of Health and Human Services, Office of Inspector General (OIG), Office of Audit Services, Region VII pension audit team reviewed the cost elements related to qualified defined-benefit, postretirement benefit, and any other pension-related cost elements claimed by Medicare contractors through Incurred Cost Proposals (ICPs).

Previous OIG audits found that Medicare contractors did not always correctly identify and claim nonqualified plan costs.

OIG's objective was to determine whether the calendar years (CYs) 2016 through 2018 nonqualified plan costs that Novitas Solutions, Inc. (Novitas), claimed for Medicare reimbursement, and reported on its ICPs, were allowable and correctly claimed.

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OIG reviewed $1.9 million of Medicare nonqualified costs that Novitas reported on its ICPs for CYs 2016 through 2018.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Novitas claimed Medicare nonqualified costs of $1.9 million for Medicare reimbursement, through its ICPs, for CYs 2016 through 2018. However, OIG determined that the allowable costs during this period were $1.8 million. The difference, $84,291, represented unallowable nonqualified costs that Novitas should not have claimed on its ICPs for CYs 2016 through 2018. This overstatement occurred primarily because Novitas based its claims for Medicare reimbursement on incorrectly calculated Cost Accounting Standards-based nonqualified costs.

OIG recommended that Novitas work with CMS to ensure that its final settlement of contract costs reflected a decrease in Medicare nonqualified costs of $84,291 for CYs 2016 through 2018.

Audit #: A-07-23-00633 (09/12/2023)
Government Program: CMS

Medicare Paid Independent Organ Procurement Organizations Over Half a Million Dollars for Professional and Public Education Overhead Costs That Did Not Meet Medicare Requirements

Organ procurement organizations (OPOs) performed or coordinated the procurement and preservation of organs, such as kidneys, as well as transportation of organs to hospitals for transplantation into patients on a waiting list to receive a transplant. Prior OIG audits found that two independent OPOs in California did not comply with Medicare requirements for reporting overhead costs as well as administrative and general costs. Specifically, professional and public education overhead costs accounted for 44 percent and 65 percent of the total amount questioned in each report, respectively. OIG conducted this nationwide audit to determine whether the issues identified in the two prior OIG audits were occurring at independent OPOs nationwide.

The objective was to determine whether independent OPOs' professional and public education overhead costs met Medicare requirements.

The audit covered $101.6 million of professional and public education overhead costs (with Medicare payments of $50.9 million) reported in the 50 independent OPOs' most recently finalized Medicare cost reports with FY end dates from May 31, 2015, through June 30, 2019 (audit period). The audit covered costs from only 1 FY for each OPO. OIG randomly sampled for review 30 professional and public education overhead costs from each of the 10 randomly selected OPOs (300 sampled costs totaling $294,692).

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that not all professional and public education overhead costs reported by independent OPOs met Medicare requirements. Of the 300 sampled professional and public education overhead costs, 264 costs met Medicare requirements. The remaining 36 costs, totaling $15,852 (with Medicare payments of $6,423), did not meet Medicare requirements and were therefore unallowable. Furthermore, while reconciling the OPOs' general ledgers with the OPOs' Medicare cost reports, OIG determined that OPOs reported an additional $132,898 of unallowable professional and public education overhead costs (with Medicare payments of $65,785).

On the basis of the sample results and additional findings OIG identified during the reconciliation, OIG estimated that $664,295 (consisting of an estimated $598,510 based on the sample results and $65,785 for the reconciliation findings) of the $50.9 million paid for professional and public education overhead costs was unallowable. The OPOs reported unallowable costs because: (1) they misunderstood Medicare requirements and (2) their staff made administrative errors or were not aware that costs did not meet Medicare requirements.

OIG recommended that CMS: (1) instruct the Medicare administrative contractor (MAC) to recover $72,208 in unallowable Medicare payments by adjusting the applicable OPOs' Medicare cost reports to correct the $148,750 of unallowable professional and public education overhead costs reported, consistent with relevant laws and the agency's policies and procedures; and (2) update applicable Medicare requirements to clarify which types of professional and public education overhead costs are unallowable, which could have saved Medicare an estimated $664,295 for professional and public education overhead costs during OIG's audit period.

Audit #: A-09-21-03020 (08/09/2023)
Government Program: CMS

Noridian Healthcare Solutions, LLC, Made $8.8 Million in Improper Monthly Capitation Payments to Physicians and Qualified Nonphysician Practitioners in Jurisdiction E for Certain Services Related to End-Stage Renal Disease

Medicare made monthly capitation payments (MCPs) to physicians and qualified nonphysician practitioners managing patients in a dialysis center. The MCP covered most outpatient dialysis-related physician services furnished to enrollees with end-stage renal disease (ESRD). In FY 2016, the Centers for Medicare & Medicaid Services estimated that there was $107 million in overpayments for ESRD-related services billed for enrollees 20 years of age and older who had four or more face-to-face visits by a physician or qualified nonphysician practitioner per month, which corresponded to an improper payment rate of 21 percent.

OIG's objective was to determine whether Noridian Healthcare Solutions, LLC (Noridian), made MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance.

OIG's audit covered Medicare Part B payments of $46.7 million for certain ESRD-related services, which OIG grouped into 189,683 enrollee-months with dates of service from April 1 through December 31, 2020 (audit period). OIG selected a random sample of 100 enrollee-months. An enrollee-month consisted of all Part B claim lines for an enrollee who received ESRD-related services and was 20 years of age or older with four or more visits by a physician or qualified nonphysician practitioner in that month.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Noridian did not make some MCPs to physicians and qualified nonphysician practitioners in Jurisdiction E for certain ESRD-related services in accordance with Medicare requirements and guidance. Of the sampled 100 enrollee-months, 74 met the requirements; however, the remaining 26 enrollee-months did not meet 1 or more of the requirements. As a result, Noridian made improper MCPs of $4,663 to physicians and qualified nonphysician practitioners. Enrollees were responsible for $1,162 in coinsurance related to the improper payments. These improper payments occurred because Noridian's oversight was not sufficient to ensure that physicians and qualified nonphysician practitioners met Medicare billing requirements for ESRD-related services. On the basis of OIG's sample results, OIG estimated that for the audit period Noridian made approximately $8.8 million in improper MCPs to physicians and qualified nonphysician practitioners for ESRD-related services. OIG also estimated that Medicare enrollees paid approximately $2.2 million in coinsurance for the improperly paid ESRD-related services.

OIG recommended that Noridian:
1. Recover $4,663 in improper payments made to physicians and qualified nonphysician practitioners for the 26 sampled enrollee-months
2. Notify the physicians and qualified nonphysician practitioners to refund $1,162 in coinsurance that was collected for the 26 sampled enrollee-months
3. Update the educational material on its website as well as any previously provided webinars to include all Medicare requirements and guidance for billing and documenting ESRD-related services and continue to perform medical record reviews as part of the Targeted Probe and Educate program, which could have saved the Medicare program an estimated $8.8 million and could have saved Medicare enrollees up to an estimated $2.2 million for the audit period.

The report contained one other recommendation.

CPT Codes Identified in This Audit:

- 90960 - ESRD-related services for an enrollee with four or more face-to-face visits during the sampled enrollee-month.

Audit #: A-09-21-03016 (06/27/2023)
Government Program: CMS

Medicare Improperly Paid Physicians an Estimated $30 Million for Spinal Facet-Joint Interventions

Medicare covered pain management procedures, such as facet-joint interventions, to treat neck or back pain resulting from arthritis in or injury to the spinal facet joints. A prior OIG audit found that for 51 of 100 sampled sessions, a Medicare contractor did not pay physicians in 1 jurisdiction for facet-joint injections in accordance with Medicare requirements. Another OIG audit found that Medicare improperly paid for facet-joint denervation sessions. Because facet-joint interventions were at risk for overutilization and prior audits had found improper payments for these services, OIG conducted this audit to determine whether Medicare improperly paid for these interventions from August 1 through October 31, 2021 (audit period).

OIG's objective was to determine whether Medicare paid physicians for spinal facet-joint interventions in accordance

with Medicare requirements and guidance.

OIG's audit covered Medicare Part B payments of $62.2 million for 425,843 claim lines for facet-joint interventions, which OIG grouped into 218,421 sessions, with dates of service during the audit period. OIG selected a statistical sample of 120 sessions. For each session, OIG reviewed beneficiaries' medical records to evaluate compliance with Medicare billing requirements and guidance but did not use medical review to determine whether interventions were medically necessary.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare did not pay physicians for some spinal facet-joint interventions in accordance with Medicare requirements and guidance. Of the 120 sampled sessions, 54 complied with Medicare requirements; however, the remaining 66 sessions did not comply with one or more of the requirements. As a result, Medicare made improper payments to physicians of $18,084. On the basis of OIG's sample results, OIG estimated that Medicare improperly paid physicians $29.6 million for facet-joint interventions for the audit period.

In addition, of the 120 sampled sessions, 43 had claim lines that were billed for at least one therapeutic facet-joint injection. Of these 43 sessions, 33 sessions did not meet Medicare guidance. Specifically, 33 sessions had claim lines that should have been billed for diagnostic instead of therapeutic facet-joint injections. This improper billing did not result in improper payments because Medicare pays the same amount for diagnostic and therapeutic facet-joint injections.

The Medicare Administrative Contractors' (MACs') education of physicians and their billing staff varied across their jurisdictions and was not always sufficient to ensure compliance with Medicare requirements and guidance.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) direct the MACs to recover $18,084 in improper payments made to physicians for the 66 sampled sessions. OIG also recommended that CMS encourage the MACs to: (1) develop collaborative training programs to be used for all of the MAC jurisdictions and that were specific to Medicare requirements for facet-joint interventions, which could have saved an estimated $29.6 million for the audit period; and (2) develop solutions to prevent the incorrect billing of diagnostic facet-joint injections as therapeutic facet-joint injections, such as developing additional education or updating guidance on how each type of injection should be billed. The report contained one other recommendation.

CPT Codes Identified in This Audit:

- 64633 - Denervation of a single facet joint in the cervical/thoracic spine
- 64635 - Denervation of a single facet joint in the lumbar/sacral spine
- 64634 - Denervation of each additional facet joint in the cervical/thoracic spine
- 64636 - Denervation of each additional facet joint in the lumbar/sacral spine
- 64490 - Injection to a single facet-joint level in the cervical/thoracic spine
- 64493 - Injection to a single facet-joint level in the lumbar/sacral spine
- 64491 - Injection to the second facet-joint level in the cervical/thoracic spine
- 64492 - Injection to the third and any additional facet-joint levels in the cervical/thoracic spine
- 64494 - Injection to the second facet-joint level in the lumbar/sacral spine
- 64495 - Injection to the third and any additional facet-joint levels in the lumbar/sacral spine

Audit #: A-09-22-03006 (03/22/2023)
Government Program: CMS

Medicare Improperly Paid Physicians for Epidural Steroid Injection Sessions

To address inappropriate billing for and overuse of epidural steroid injections, 10 of the 12 Medicare Administrative Contractors' (MACs') jurisdictions developed coverage limitations, through Local Coverage Determinations (LCDs), for epidural steroid injection sessions. These coverage limitations allowed for physicians to be reimbursed for a maximum number of epidural steroid injection sessions in a 6-month or a 12-month period.

Prior Office of Inspector General audits found that Medicare did not always pay physicians for spinal facet-joint denervation and injection sessions in accordance with Federal requirements.

The objective was to determine whether Medicare paid physicians for epidural steroid injection sessions in accordance with Medicare requirements.

During the audit period (January 1, 2019, to December 31, 2020), the MACs paid physicians $52.8 million for 303,408 epidural steroid injection sessions. OIG analyzed the 303,408 sessions and identified 80,419 sessions totaling $13.8 million that exceeded the coverage limitation for the respective MAC jurisdiction.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare did not always pay physicians for epidural steroid injection sessions in accordance with Medicare requirements. For the audit period, Medicare improperly paid physicians $3.6 million on behalf of beneficiaries who received more epidural steroid injection sessions than were permitted by the coverage limitations in the applicable LCDs. These improper payments occurred because neither the Centers for Medicare & Medicaid Services's (CMS's) oversight nor the MACs' oversight was adequate to prevent or detect improper payments for epidural steroid injection sessions.

After the audit period, all 12 MAC jurisdictions updated their LCDs with revised coverage limitations that were specific to epidural steroid injections.

OIG recommended that CMS:

(1) direct the MACs to recover the $3.6 million in improper payments made to physicians for epidural steroid injection sessions;
(2) instruct the MACs to, based on the results of this audit, notify appropriate physicians (i.e., those for whom CMS determined this audit constituted credible information of potential overpayments) so that the physicians could exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;
(3) assess the effectiveness of oversight mechanisms, put in place after OIG's audit period, that were specific to preventing or detecting improper payments to physicians for more than the allowed number of epidural steroid injection sessions, and modify the oversight mechanisms, if necessary, based on that assessment; and
(4) direct the MACs (or other designated entities) to review a sample of claims for injection sessions administered after OIG's audit period but before the revised coverage limitations became effective to identify and recover any improper

payments.

CPT Codes Identified in This Audit:

- 62320 - 62321
- 62325 - Injection of anesthetic and/or steroid drug into the cervical or thoracic spinal region with imaging guidance and contrast
- 64479 - 64480
- 64483 - 64484

Audit #: A-07-21-00618 (03/10/2023)
Government Program: CMS

Medicare Providers Did Not Always Comply With Federal Requirements When Billing for Advance Care Planning

Advance care planning (ACP) is a service consisting of a face-to-face discussion between Medicare physicians or other qualified health care professionals and patients to discuss their wishes if they became unable to make decisions about their care. Effective January 1, 2016, Medicare began paying for ACP services. Payments for ACP provided from 2016 through 2019 totaled more than $340 million. Payments for services provided in an office setting represented 61 percent of all payments.

OIG's objective was to determine whether Medicare providers who received payments for ACP services in an office setting complied with Federal requirements.

The audit covered 873,381 beneficiaries associated with claims for ACP services (CPT codes 99497 and 99498) in an office setting during calendar year 2019 (audit period) with a total paid amount of $70.1 million. OIG selected for review a stratified random sample of 125 beneficiaries. OIG reviewed all 691 paid ACP services for the 125 beneficiaries selected for the sample.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that Medicare providers that billed for ACP services in an office setting did not always comply with Federal requirements. Specifically, of the 691 ACP services associated with the sample, Medicare providers complied with Federal requirements for 225 services totaling $15,874. However, providers did not comply with Federal requirements for 466 services totaling $33,332.

On the basis of the sample results, OIG estimated that Medicare providers in an office setting were paid approximately $42.3 million for ACP services that did not comply with Federal requirements. These payments occurred because the providers did not understand the Federal requirements for billing ACP services.

OIG also identified questionable claims associated with 12 sampled beneficiaries for whom 15 or more ACP services were received. Although the billing of these ACP services did not reflect noncompliance with Medicare requirements, the billings did not align with guidance contained in CMS's Frequently Asked Questions.

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OIG recommended that CMS educate providers on documentation and time requirements for ACP services to comply with Federal requirements. Had the requirements been followed, Medicare could have saved an estimated $42.3 million during OIG's audit period. In addition, CMS should instruct the MACs to recoup $33,332 for ACP services paid in error for claims in OIG's sample. Also, CMS should instruct the MACs to notify appropriate providers so that they could exercise reasonable diligence in identifying, reporting, and returning any overpayments in accordance with the 60-day rule. Finally, CMS should establish Medicare requirements that addressed when it was appropriate to provide multiple ACP services for a single beneficiary and how these services should be documented when required to support the need for multiple ACP services.

CPT Codes Identified in This Audit:

- 99497 - Covers the first 30 minutes of Advance Care Planning (ACP), which includes a face-to-face explanation and discussion of advance directives, such as standard forms, between the provider and the patient, family member(s) or a surrogate, or both
- 99498 - Should be used for each additional 30 minutes of ACP and listed separately in addition to code 99497.

Audit #: A-06-20-04008 (11/22/2022)
Government Program: CMS

Medicare Improperly Paid Physicians for Co-Surgery and Assistant-at-Surgery Services That Were Billed Without the Appropriate Payment Modifiers

Under the Medicare Part B program, the Centers for Medicare & Medicaid Services (CMS) made a reduced payment to physicians who worked together as co-surgeons to perform a surgical procedure on the same patient during the same operative session. OIG conducted this audit because of the potential risk that Medicare was overpaying physicians for co-surgery procedures billed without the appropriate modifier.

OIG's objective was to determine whether Medicare Part B payments to physicians for potential co-surgery procedures complied with Federal requirements.

OIG's audit covered $15.4 million in Medicare Part B payments for services performed during calendar years 2017 through 2019 (audit period) in which two different providers separately billed an identical procedure code for the same beneficiary and on the same day. OIG selected a stratified random sample of 100 services for review that were billed by one of the providers from the sampling frame without a co-surgery or assistant-at-surgery modifier. OIG also identified and reviewed 127 corresponding services that were billed by providers with the same procedure code for the same beneficiary on the same day as the sampled services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that from OIG's 100 statistically sampled services, 69 did not comply with Federal requirements. Specifically, these statistically sampled services included 49 that were incorrectly billed without the co-surgery modifier, 14 that were incorrectly billed without an assistant-at-surgery modifier, and 6 that were incorrectly billed as duplicate services. These statistically sampled service errors resulted in overpayments of $31,545. Based on the results of OIG's statistical sample, it was estimated that Medicare made $4.9 million in improper payments for physician surgical services during the audit period. In addition to the statistically sampled services, based on OIG's review of the 127 corresponding

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Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

services, it was further found that 62 of these corresponding services did not comply with Federal requirements. These corresponding service errors resulted in overpayments of $24,471. Altogether, these statistically sampled and corresponding service errors occurred primarily because CMS did not have adequate system controls to identify and prevent such payments.

OIG recommended that CMS: (1) recover the portion of the $56,016 in Medicare Part B overpayments that were within the 4-year claim reopening period; (2) instruct the Medicare contractors to, based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determined this audit constituted credible information of potential overpayments) so that the providers could exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) strengthen its system controls to detect and prevent improper payments to providers for incorrectly billed co-surgery services, assistant-at-surgery services, and duplicate services—which could have saved approximately $4.9 million during the audit period; and (4) update Medicare requirements and corresponding educational material to improve providers' understanding of the Part B billing requirements for co-surgery procedures.

CPT Codes Identified in This Audit:

- 33880 - Thoracic endovascular repair procedure
- 28299 - Bilateral bunion correction procedure
- 19364 - Bilateral breast removal procedure
- 27447 - Bilateral knee replacement procedure
- 22840 - Spinal instrumentation code
- 22848 - Spinal instrumentation code
- 22850 - Spinal instrumentation code
- 22852 - 22854
- 22859 - Spinal instrumentation code
- 63030 - Spinal laminectomy and decompression procedure

Audit #: A-01-20-00503 (11/22/2022)
Government Program: CMS

Medicare Dialysis Services Provider Compliance Audit - Dialysis Clinic, Inc.

Medicare Part B covered dialysis services for beneficiaries with end-stage renal disease (ESRD). Prior OIG reviews identified inappropriate Medicare payments made for ESRD dialysis services that were medically unnecessary, not properly ordered, undocumented, or did not comply with Medicare consolidated billing requirements.

OIG selected Dialysis Clinic, Inc. (DCI), because it ranked among the highest paid providers of dialysis services in the United States, and Medicare surveyors identified various health and safety issues.

OIG's objective was to determine whether dialysis services provided by DCI complied with Medicare requirements.

OIG's audit covered 112,192 claims for dialysis services provided during the audit period (calendar year 2018) for which DCI received Medicare reimbursement totaling $276,427,841. OIG reviewed a random sample of 100 claims. OIG evaluated the services for compliance with Medicare requirements and submitted them to independent medical review.

SUNHAWK CONSULTING

Provider

Multiple Providers

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Telehealth

Other Providers and Suppliers

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that DCI claimed reimbursement for dialysis services that did not comply with Medicare requirements for 70 of the 100 sampled claims. Specifically, DCI submitted claims for which: (1) comprehensive assessments or plans of care did not meet Medicare requirements, (2) dialysis treatments were not completed, (3) dialysis services were not documented, (4) beneficiaries' height or weight measurements did not comply with Medicare requirements, and (5) the medical record did not have a monthly progress note by a physician or other qualified professional.

While DCI had established corporate-wide internal controls to monitor and maintain complete, accurate, and accessible medical records at all its facilities, these controls were not always effective in ensuring that DCI's claims for dialysis services complied with Medicare requirements.

OIG estimated that DCI received unallowable Medicare payments of at least $14,193,677 for dialysis services that did not comply with Medicare requirements. Many of the errors OIG identified did not affect DCI's Medicare reimbursement for the services since they were reimbursed on a bundled per treatment basis or related to Medicare conditions for coverage. However, the deficiencies could have had a significant impact on the quality of care provided to Medicare beneficiaries and could have resulted in the provision of inappropriate or unnecessary dialysis services.

OIG recommended that DCI refund an estimated $14,193,677 to the Medicare program. OIG also made a series of recommendations to strengthen DCI's internal controls to ensure that dialysis services complied with Medicare requirements.

HCPCS Codes Identified in This Audit:

- V502 - Comprehensive assessments used with care plans include assessment of all elements covered in V502
- V515 - Comprehensive assessments used with care plans include assessment of all elements covered in V515
- V555 - Rehabilitation Status
- V562 - Education and Training
- V552 - Psychosocial Status
- V550 - Vascular Access Monitoring
- V543 - Dialysis Dose

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