# Healthcare Audit and Enforcement Risk Analysis

## HHS OIG Work Plan Summary Report Provider Focus

### Active Work Plan Items

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**To our Compliance Colleagues and Partners:**

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

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

After your review, we would appreciate any feedback that would make this report more valuable to you or others. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to 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.

# Table of Contents



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# Provider





## Hospital

### *[NEW]* Inpatient Claims for Neurostimulator Implantation Surgeries

**Announced:** March 2026
**Estimated Completion:** FY2028

Certain medical devices such as neurostimulators may be implanted during an inpatient procedure. Medicare covers the initial implantation and replacements or revisions to the device. Hospitals must meet Federal requirements for neurostimulator implantation surgeries to be covered by Medicare. Prior OIG audit work determined that Medicare made improper payments to hospitals for outpatient claims for neurostimulator implantation surgeries. Currently, CMS requires prior authorization for outpatient neurostimulator implantation surgeries, but not for inpatient neurostimulator implantation surgeries. Prior authorization helps CMS ensure that applicable requirements are met before the services are provided. CMS's lack of prior authorization for inpatient neurostimulator implantation surgeries may leave this area vulnerable to potential improper payments. OIG will determine whether CMS made Medicare payments to hospitals for inpatient neurostimulator implantation surgeries in accordance with Federal requirements.

**Project Number:** OAS-26-01-035
**HHS Agencies:** Centers for Medicare and Medicaid Services

### Medicare Inpatient Hospital Billing for Sepsis

**Announced:** March 2024
**Estimated Completion:** FY2026

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

**Project Number:** OEI-02-24-00230
**HHS Agencies:** Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention

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**Hospital**

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Series: Medicare Administrative Contractor Cost Report Settlements with Audit

**Announced:** May 2022
**Estimated Completion:** FY2026

**Active Projects:** OAS-25-06-154
**Projects Completed:** A-06-24-05004, A-06-24-05003, A-06-24-04001, A-06-24-05000, A-06-23-05001, A-06-22-05000

HHS contracts with Medicare Administrative Contractors (MACs) to process claims and cost reports and determine payment amounts to providers (Social Security Act, Â§ 1874A(a)). MACs determine the total amount of reimbursement based on providers' cost reports. MACs perform a desk review, and at their discretion, may perform either a field audit or an in-house audit to determine the cost report's adequacy, completeness, and accuracy. Generally, some cost reports that have been audited and settled are later reopened to correct audit adjustments. CMS has stated that it does not maintain data related to the number of cost reports that are reopened, the monetary adjustments to the settlement made as a result of reopenings, or the types and/or causes of adjustments. OIG's objective will be to: (1) quantify the extent to which the MAC amends audit adjustments after cost reports have been audited and settled, and whether the audit adjustments contain obvious errors or are inconsistent with the law, regulations and rulings, or general instructions; (2) quantify the effect of amended audit adjustments; and (3) gain an understanding of the types and/or causes of amended audit adjustments. Initially, OIG will audit a single MAC, and based on the results, OIG may expand this work to others.

**Series Number:** W-00-24-35886
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Audits of Medicare Emergency Department Evaluation and Management Services

**Announced:** September 2021
**Estimated Completion:** FY2026

**Active Projects:** A-03-21-00004, A-03-24-00001

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

**Series Number:** W-00-24-35877
**HHS Agencies:** Centers for Medicare and Medicaid Services

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## Series: Selected Inpatient and Outpatient Billing Requirements

**Announced:** September 2021
**Estimated Completion:** FY2026

**Active Projects:** A-07-21-05134, A-07-21-05133, A-04-22-07101, A-02-22-01022, A-04-23-08095, A-09-23-03001, A-05-23-00004, A-04-23-07104, A-03-23-00001, A-07-24-05147, A-07-24-05148, OAS-25-04-089, OAS-26-02-096
**Projects Completed:** A-04-23-08098, A-02-20-01004, A-04-19-08077, A-05-19-00024, A-02-18-01025, A-02-18-01018, A-04-19-08075, A-07-18-05113, A-05-18-00045, A-05-18-00048, A-04-19-08071, A-07-18-05112, A-05-18-00042, A-03-18-00005, A-04-18-08068, A-05-18-00040, A-04-18-08064, A-04-18-08063

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

**Series Number:** SRS-A-25-012
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: CMS Oversight of the Two-Midnight Rule for Inpatient Admissions

**Announced:** July 2021
**Estimated Completion:** FY2026

**Active Projects:** A-04-24-03004
**Projects Completed:** A-09-21-03022

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

**Series Number:** W-00-24-35857
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

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

## Series: Audits of the Effectiveness of HHS's Governance To Ensure Hospitals Implement Measures To Prevent, Detect, and Recover From Cyberattacks

**Announced:** April 2021
**Estimated Completion:** FY2026

**Active Projects:** A-18-22-08021, OAS-25-18-032, OAS-25-18-033, OAS-25-18-108
**Projects Completed:** A-18-22-08019, A-18-21-08014

Ransomware, destructive malware, insider threats, and even honest mistakes present an ongoing threat to U.S. hospital operations and the security of electronic protected health information (ePHI).The more quickly and effectively hospitals detect and respond to attacks that may affect the availability and integrity of their data, the more likely they may avoid service disruptions that could potentially affect patient data or lives and save time and money that would be required to recover from such attacks. In recent years, multiple hospitals have fallen prey to significant cyberattacks, including ransomware attacks during the COVID-19 pandemic that have impacted hospital operations and patient care. In October 2020, the Cybersecurity and Infrastructure Security Agency, Federal Bureau of Investigation, and Department of Health and Human Services (HHS) issued a joint cybersecurity advisory regarding ransomware activity targeting the health care and public health sector. The advisory stated that threat actors have continued to develop new functionality and tools, thereby increasing the ease, speed, and profitability of ransomware attacks.HHS-OIG will audit HHS's governance over its programs to determine whether HHS's Office of Civil Rights (OCR) has performed periodic audits of hospitals to assess compliance with Health Insurance Portability and Accountability Act (HIPAA) Security, Privacy, and Breach Notification rules and determine whether these audits effectively assessed ePHI protections. In addition, the OIG will determine whether CMS's certification process for participation in the Medicare program requires hospitals participating in the Medicare program to implement minimum security safeguards to prevent and detect cyberattacks, ensure continuity of patient care, and protect beneficiary data. The OIG will also conduct security assessments at 10 U.S. hospitals to determine whether they have adequately implemented HIPAA security requirements or effective cybersecurity measures to prevent, detect, and recover from cyberattacks.

**Series Number:** W-00-24-42035
**HHS Agencies:** Office for Civil Rights, Office of the Secretary, Centers for Medicare and Medicaid Services

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# Long Term Care

### *[NEW]* Implementation and Effectiveness of Nursing Home Pharmacy Service Internal Controls to Prevent Opioid Overuse, Misuse, and Diversion

**Announced:** February 2026
**Estimated Completion:** FY2028

Pharmaceutical services are an integral part of the care required to meet the needs of each nursing home resident. Nursing homes must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs). Nursing homes are also required to: (1) store all drugs in locked compartments; (2) permit only authorized personnel to have access to the keys to secured areas; and (3) provide separately locked, permanently affixed compartments for storage of Schedule II controlled drugs. State survey agencies cited almost half of nursing homes nationwide for pharmaceutical services deficiencies during recent complaint and standard health inspections. If effective systems and procedures to ensure the safe and effective use of medications are not implemented, over 157,000 nursing home residents who receive opioids could be at risk for overuse, misuse, or diversion. OIG will determine whether selected State agencies ensured that nursing homes: (1) complied with Federal and State pharmacy service requirements to prevent the overuse of opioids by Medicaid and Medicare residents and (2) implemented effective internal controls to prevent the misuse or diversion of opioids.

**Project Number:** OAS-26-01-027
**HHS Agencies:** Centers for Medicare and Medicaid Services

### CMS Efforts to Ensure Nursing Home Quality After Changes in Ownership

**Announced:** November 2025
**Estimated Completion:** FY2027

In recent years, regulators and policymakers have raised concerns about the relationship between changes in nursing home ownership and low-quality care, which can endanger resident health and safety. CMS requires nursing homes to submit updated information within 30 days of a change in ownership. In addition, CMS and State survey agencies can assess the effect of ownership changes on quality by conducting an onsite survey, making a State monitoring visit, and/or requesting additional documentation. This study will evaluate the extent to which CMS and State survey agencies take actions to identify and respond to declines in nursing home quality related to changes in ownership.

**Project Number:** OEI-01-25-00250
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Monitoring Nursing Homes' Engagement of Medical Directors

**Announced:** June 2025
**Estimated Completion:** FY2027

Medical directors at nursing homes are responsible for implementing resident care policies, coordinating medical care, and participating in quality assessment and assurance activities. Nursing homes are required to report hours worked by medical directors to CMS's Payroll-Based Journal (PBJ). The reported hours have raised concerns about nursing homes' employment and engagement of medical directors. But there may be limitations to the accuracy and utility of PBJ data on medical director hours. In this evaluation, OIG will assess: (1) the extent to which medical directors performed required duties in nursing homes, (2) the extent to which PBJ data on medical director hours are accurate and useful for oversight, and (3) opportunities to improve oversight and transparency of nursing homes' engagement and funding of medical directors through existing data or other monitoring mechanisms.

**Project Number:** OEI-07-25-00130
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Audit of Selected States' Nursing Home Minimum Spending Requirements Related to Resident Care

**Announced:** May 2025
**Estimated Completion:** FY2027

Previous OIG work has highlighted the importance of understanding how Medicaid spending has an impact on the care provided to residents in nursing homes. Certain States have established their own nursing home minimum spending requirements related to resident care. OIG will perform an audit that provides CMS and other stakeholders (e.g., Congress and States) with information on how these States ensure that nursing home revenues are related to resident care expenditures. OIG will determine how the States have implemented nursing home minimum spending requirements related to resident care and identify challenges that the States and nursing homes have experienced in implementing and complying with those requirements.

**Project Number:** OAS-25-09-086
**HHS Agencies:** Centers for Medicare and Medicaid Services

## SNFs Financial Responsibility for Drugs for Medicare Part D Enrollees in Part A SNF Stays

**Announced:** April 2025
**Estimated Completion:** FY2027

Medicare Part A prospective payments to skilled nursing facilities (SNFs) cover most services, including drugs and biologicals, furnished by a SNF for use in the facility for the care and treatment of enrollees. Accordingly, Medicare Part D drug plans should not pay for prescription drugs related to posthospital SNF care, because payment for the drugs is included in the prospective payment for a Part A SNF stay. A prior OIG audit found that up to $465.1 million in Part D total cost was improperly paid for drugs for which payment was available under the Part A SNF benefit. That audit also found that some of the drugs administered to Part D enrollees during their Part A SNF stays had been provided to the SNFs by the enrollees or their families, even though the SNFs were financially responsible for providing the drugs. For this audit, OIG will determine whether SNFs complied with Federal requirements for assuming financial responsibility for drugs for Part D enrollees in Part A SNF stays. For instances in which drugs used during enrollees' Part A SNF stays were provided by the enrollees or their families and paid for by Part D, OIG will determine why the SNFs obtained the drugs from the enrollees or their families.

**Project Number:** OAS-25-09-057
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Medicaid Nursing Facility Supplemental Payments

**Announced:** April 2024
**Estimated Completion:** FY2026

**Active Projects:** A-05-24-00017, OAS-26-05-039, OAS-26-05-048

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

**Series Number:** WA-24-0038
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

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

**Announced:** January 2024
**Estimated Completion:** FY2026

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

**Project Number:** A-04-24-08105
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Project A-09-24-02005

**Announced:** November 2023
**Estimated Completion:** FY2026

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

**Project Number:** A-09-24-02005
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Series: Audits of Emergency Preparedness, Infection Prevention and Control, and Life Safety at Intermediate Care Facilities for Individuals With Intellectual Disabilities

**Announced:** November 2023
**Estimated Completion:** FY2026

**Active Projects:** OAS-25-09-113
**Projects Completed:** OAS-25-06-029, OAS-25-01-040, A-04-24-02504, A-06-24-09002, A-01-24-00004, A-01-24-00001

An Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) is an institution that provides health and/or rehabilitation services to individuals with intellectual disabilities under the Medicaid program. ICF/IID services are covered by Medicaid when they are provided in a residential facility licensed and certified by a State survey agency as an ICF/IID. Medicaid covers ICF/IID services for more than 100,000 individuals with intellectual disabilities and other related conditions. ICF/IIDs face significant challenges in the event of emergencies such as fires, emerging infectious disease outbreaks, and natural disasters. Previous OIG audits on infection prevention and control, emergency preparedness, and life safety at nursing homes identified multiple issues that put Medicaid enrollees at increased risk. OIG's objective is to determine whether selected States' ICF/IIDs complied with Federal requirements for infection prevention and control, emergency preparedness, and life safety.

**Series Number:** SRS-A-25-026
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Background Checks for Nursing Home Employees

**Announced:** March 2023
**Estimated Completion:** FY2026

**Active Projects:** A-02-24-01012
**Projects Completed:** OAS-25-01-035, A-05-24-00011, A-02-23-01011, A-09-23-02003, A-04-24-08104, A-04-23-08100, A-06-21-02000

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

**Series Number:** W-00-24-31553
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Potentially Preventable Hospitalizations of Medicare-Eligible Skilled Nursing Facility Residents

**Announced:** October 2022
**Estimated Completion:** FY2026

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

**Project Number:** A-06-23-02000
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Skilled Nursing Facility Reimbursement

**Announced:** July 2022
**Estimated Completion:** FY2026

**Active Projects:** OAS-25-02-115, OAS-25-01-053, OAS-25-02-146, OAS-26-05-075, OAS-26-05-091
**Projects Completed:** A-02-22-01017

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

**Series Number:** SRS-A-25-010
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Audit of Medicare Part B Services Provided to Patients Residing in Nursing Homes

**Announced:** January 2021
**Estimated Completion:** FY2026

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

**Project Number:** A-06-21-04002
**HHS Agencies:** Centers for Medicare and Medicaid Services

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## Provider

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

# Home Health Service

### *[NEW]* Nationwide Medicare Compliance Audit of Home Health Claims Billed With an Institutional Admission Source

**Announced:** April 2026
**Estimated Completion:** FY2028

For home health services beginning on or after January 1, 2020, Centers for Medicare & Medicaid Services (CMS) implemented a revised case-mix adjustment methodology, the Patient-Driven Groupings Model (PDGM). The PDGM assigns 30-day periods of care into one of 432 case-mix groups based upon five variables, one of which is admission source (i.e., from the community or from an acute or post-acute care facility, also known as an institutional admission source). CMS created two new occurrence codes, 61 and 62, to allow home health agencies (HHAs) to indicate that an institutional stay occurred within 14 days of the home health admission. HHA institutional admissions result in higher reimbursement than community admissions, and HHAs may report institutional admissions using these codes even when no corresponding Medicare inpatient claim exists. Prior OIG audits found HHAs incorrectly billed institutional admissions using occurrence codes, sometimes based on emergency room visits or observation stays that do not qualify as inpatient stays. OIG will determine whether home health claims billed with occurrence codes 61 or 62 were submitted in accordance with Medicare source of admission billing and coding requirements. OIG's review will assess documentation supporting admission source and identify vulnerabilities that allow improper payments.

**Project Number:** OAS-26-05-056
**HHS Agencies:** Centers for Medicare and Medicaid Services

### Medicare Payments for Home Health Comorbidity Adjustments

**Announced:** December 2025
**Estimated Completion:** FY2027

Medicare payments to home health agencies (HHAs) exceeded $16 billion in calendar year 2024. These payments are adjusted by the case mix of the enrollees receiving services. HHAs receive higher payments when diagnosis codes indicate specific comorbidities, and CMS data show that about 70 percent of claims received a comorbidity adjustment in 2023 and 2024. To determine the extent of potential improper HHA coding and potential savings, OIG will analyze a subset of HHA claims that received increased payments for select comorbidities and assess whether non-HHA claims also identified the same condition.

**Project Number:** OEI-04-26-00070
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Incorrectly Billed Visit Units That Trigger Outlier Payments on Home Health Claims

**Announced:** November 2025
**Estimated Completion:** FY2027

Medicare requires providers to bill claims accurately to be paid correctly and promptly by Medicare Administrative Contractors (MACs). During previous home health agency compliance work, OIG observed claims where providers incorrectly billed single-discipline visit units (greater than 8 hours) that resulted in overpayments equal to the outlier payment. MACs pay outlier payments on home health claims for enrollees who incur unusually large costs that are determined by the visit units billed on the claim. Nationwide home health claims data for the most recent 30-month period shows that the average duration of a home health visit is 45 minutes. OIG's audit will cover Medicare outlier payments for home health visits for single disciplines that were billed in excess of 4 hours. OIG's objective is to determine whether selected home health claims with outlier payments complied with certain Medicare billing requirements.

**Project Number:** OAS-26-05-001
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Medicare Payments for Home Dialysis Services

**Announced:** December 2023
**Estimated Completion:** FY2026

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

**Project Number:** A-05-24-00006
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

**Home Health Service**

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Series: Home Health Compliance with Medicare Requirements

**Announced:** April 2022
**Estimated Completion:** FY2026

**Active Projects:** A-05-24-00007
**Projects Completed:** A-02-22-01023, A-05-24-00014, A-07-24-05146, A-05-22-00016, A-05-23-00002, A-05-22-00017, A-05-23-00017

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

**Series Number:** W-00-24-35712
**HHS Agencies:** Centers for Medicare and Medicaid Services

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## Provider

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

# Hospice

## Trends and Patterns in Data Related to Newly Enrolled Hospice Providers

**Announced:** April 2025
**Estimated Completion:** FY2027

Federal requirements state that hospices must be certified by CMS and be licensed as required by State and local law. Medicare also requires that hospices meet its Conditions of Participation to receive payment. The OIG's objective is to identify trends, patterns, and key comparisons that indicate potential vulnerabilities related to new Medicare hospice provider enrollments. The data brief may help CMS evaluate the need for additional monitoring and program integrity efforts to ensure that hospices meet all the requirements.

**Project Number:** OAS-25-09-034
**HHS Agencies:** Centers for Medicare and Medicaid Services

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

**Announced:** June 2023
**Estimated Completion:** FY2026

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

**Project Number:** A-02-23-01021
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Series: Review of Hospices' Compliance with Medicare Requirements

**Announced:** January 2023
**Estimated Completion:** FY2026

**Active Projects:** A-02-22-01021, A-02-23-01005, A-09-23-03004, OAS-26-02-040, A-04-23-07105, A-02-23-01018, A-04-23-07109, A-04-24-07112

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

**Series Number:** W-00-24-35783
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Medicare Payments Made Outside of the Hospice Benefit

**Announced:** February 2020
**Estimated Completion:** FY2026

**Active Projects:** OAS-25-09-009
**Projects Completed:** A-09-23-03024, A-09-20-03015, A-09-20-03026

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

**Series Number:** W-00-24-35797
**HHS Agencies:** Centers for Medicare and Medicaid Services

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## Provider



# Medical Equipment and Supplies

## White Paper: Fraud, Waste, and Abuse Related to Durable Medical Equipment in Medicare

**Announced:** August 2025
**Estimated Completion:** FY2027

Each year, Medicare payments for durable medical equipment, prosthetics, orthotics, and supplies (also known as DMEPOS) top more than $7 billion in original Medicare alone. Despite safeguards and other CMS efforts, recent cases demonstrate that fraudsters continue to target DMEPOS billing and have developed new schemes. This white paper will build on OIG's extensive expertise on DMEPOS fraud. It will provide information about the nature of DMEPOS fraud in Medicare, key program integrity vulnerabilities, and potential actions to reduce fraud, waste, and abuse.

**Project Number:** OEI-02-24-00311
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Audits of the Medicare Enrollment Screening Process for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

**Announced:** July 2025
**Estimated Completion:** FY2027

**Active Projects:** OAS-25-04-091, OAS-25-04-127

Suppliers who receive fee for service/traditional Medicare reimbursement for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) are required to enroll in Medicare. On November 7, 2022, the Centers for Medicare & Medicaid Services began using National Provider Enrollment (NPE) administrative contractors to oversee the enrollment process and to screen all initial applications, revalidation applications, and certain other applications. Because DMEPOS suppliers' enrollment screening by NPE contractors is a relatively new requirement, and DMEPOS continues to be a target of fraudulent billing schemes, OIG will determine whether the NPE contractors conducted enrollment screenings for DMEPOS suppliers in accordance with Federal regulations.

**Series Number:** SRS-A-25-030
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

**Medical Equipment and Supplies**

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Medicare Payments for Parenteral Nutrition Services

**Announced:** June 2025
**Estimated Completion:** FY2027

Parenteral nutrition is a form of intravenous feeding that delivers nutrients directly into a vein. Medicare Part B covers the reasonable and necessary costs of durable medical equipment, prosthetics, orthotics, and supplies, which include parenteral nutrition (Social Security Act §§ 1861(s)(8) and 1862(a)(1)(A)). For CYs 2022 and 2023, Medicare paid more than $487 million for parenteral nutrition. For both years, CMS's Comprehensive Error Rate Testing reports identified improper payments due to a lack of documentation showing medical necessity, coding errors, and insufficient or no documentation. OIG will determine whether Medicare paid suppliers of durable medical equipment, prosthetics, orthotics, and supplies for parenteral nutrition in accordance with Medicare requirements.

**Project Number:** OAS-25-04-079
**HHS Agencies:** Centers for Medicare and Medicaid Services

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

**Announced:** February 2025
**Estimated Completion:** FY2027

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

**Project Number:** OEI-03-25-00080
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

**Medical Equipment and Supplies**

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Medicare Payments to Suppliers for Oxygen and Oxygen Equipment

**Announced:** October 2024
**Estimated Completion:** FY2026

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

**Project Number:** OAS-24-09-012
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Wheelchair Repair Services for Medicare Enrollees

**Announced:** October 2024
**Estimated Completion:** FY2026

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

**Project Number:** OEI-07-24-00380
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

**Medical Equipment and Supplies**

Behavioral Health

Laboratory

Prescriber

Telehealth

Other Providers and Suppliers

## Durable Medical Equipment Fraud and Safeguards in Medicare

**Announced:** June 2024
**Estimated Completion:** FY2026

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

**Project Number:** OEI-02-24-00310
**HHS Agencies:** Centers for Medicare and Medicaid Services

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

**Announced:** September 2023
**Estimated Completion:** FY2026

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

**Project Number:** A-05-23-00021
**HHS Agencies:** Centers for Medicare and Medicaid Services

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## Provider

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

# Behavioral Health

## Series: Audit of Certified Community Behavioral Health Clinics Medicaid Reimbursement and Compliance With Demonstration Requirements

**Announced:** November 2025
**Estimated Completion:** FY2027

**Active Projects:** OAS-25-06-109

Certified Community Behavioral Health Clinics (CCBHCs) provide whole-person, team-based care addressing both behavioral and physical health needs. They are required to offer a broad range of services, including crisis mental health care, case management, and integrated physical health screening. Section 223 of the Protecting Access to Medicare Act of 2014 authorized the creation of a demonstration program for CCBHCs. States participating in the CCBHC demonstration receive Federal funds at the enhanced Federal medical assistance percentage (FMAP) for qualifying expenditures and are required to implement standardized certification and payment structures for CCBHCs. OIG will determine whether select States participating in the CCBHC demonstration program claimed expenditures that were eligible for the enhanced FMAP and whether select CCBHCs provided the services required to receive Medicaid payments.

**Series Number:** SRS-A-26-025
**HHS Agencies:** Centers for Medicare and Medicaid Services

# Laboratory

## *[NEW]* Medicare Payments for Clinical Diagnostic Laboratory Tests in 2025

**Announced:** April 2026
**Estimated Completion:** FY2028

Medicare is the largest payer of clinical laboratory services in the United States. Medicare Part B covers most lab tests and pays 100 percent of allowable charges. The Protecting Access to Medicare Act of 2014 (PAMA), Pub. L. No. 113-93, requires the Centers for Medicare & Medicaid Services (CMS) to set payment rates for lab tests using current charges in the private health care market, under Title XVIII of the Social Security Act (PAMA, § 216(a)). On January 1, 2018, CMS began paying for lab tests under the new system mandated by PAMA. PAMA also requires OIG to publicly release an annual analysis of the top 25 laboratory tests by expenditures (Pub. L. No. 113-93 § 216(c)(2)(A)). In accordance with PAMA, OIG will publicly release an analysis of the top 25 laboratory tests by expenditures for 2025.

**Project Number:** OEI-09-26-00220
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Audits of Medicaid Reimbursement for Clinical Laboratory Services

**Announced:** October 2024
**Estimated Completion:** FY2026

**Active Projects:** OAS-25-01-004, OAS-25-01-076, OAS-25-01-084, OAS-25-06-095, OAS-25-05-120, OAS-26-04-005, OAS-26-01-034, OAS-26-01-089

Outpatient clinical diagnostic laboratory tests encompass tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory, and provide information for the diagnosis, prevention, or treatment of disease or for the assessment of a medical condition. Medicaid reimbursement for outpatient clinical diagnostic laboratory services performed in a physician's office, by an independent laboratory, or by a hospital laboratory, generally may not exceed the amount set in the Medicare clinical laboratory fee schedule. The OIG's objective is to determine whether selected States claimed Federal Medicaid reimbursement for outpatient clinical diagnostic laboratory services in accordance with the payment limits set in Federal and State requirements.

**Series Number:** SRS-A-25-002
**HHS Agencies:** Centers for Medicare and Medicaid Services

# Prescriber

## Joint Pain Management Therapies: Hyaluronic Acid Knee Injections

**Announced:** August 2024
**Estimated Completion:** FY2026

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

**Project Number:** A-07-24-00646
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Audits of Medicare Payments for Spinal Pain Management Services

**Announced:** September 2019
**Estimated Completion:** FY2026

**Active Projects:** OAS-25-09-021
**Projects Completed:** A-09-23-03013, A-09-22-03006, A-07-21-00618, A-09-21-03002, A-09-20-03010, A-09-20-03003

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

**Series Number:** SRS-A-25-006
**HHS Agencies:** Centers for Medicare and Medicaid Services

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## Provider

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

# Telehealth

## Audit of Medicare Part B Remote Patient Monitoring Services

**Announced:** December 2024
**Estimated Completion:** FY2026

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

**Project Number:** OAS-25-05-008
**HHS Agencies:** Centers for Medicare and Medicaid Services

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## Provider

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

# Other Providers and Suppliers

## Medicare Part B Payments for Incident To Services

**Announced:** November 2024
**Estimated Completion:** FY2026

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

**Project Number:** OAS-25-01-003
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Medicare Part B Payments for Skin Substitutes

**Announced:** November 2024
**Estimated Completion:** FY2026

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

**Project Number:** OAS-25-09-005
**HHS Agencies:** Centers for Medicare and Medicaid Services

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# Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment and Supplies

Behavioral Health

Laboratory

Prescriber

Telehealth

**Other Providers and Suppliers**

## Series: Nationwide Audits of Organ Procurement Organizations and Certified Transplant Centers

**Announced:** May 2024
**Estimated Completion:** FY2026

**Active Projects:** A-07-24-00643, A-09-24-03009, A-09-24-03010, OAS-25-07-123, OAS-25-07-124

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

**Series Number:** SRS-A-25-031
**HHS Agencies:** Centers for Medicare and Medicaid Services

## Series: Medicaid Targeted Case Management

**Announced:** July 2022
**Estimated Completion:** FY2026

**Active Projects:** A-07-24-03259, OAS-25-02-024
**Projects Completed:** A-07-22-03253

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

**Series Number:** W-00-24-31082
**HHS Agencies:** Centers for Medicare and Medicaid Services