Healthcare Audit and Enforcement Risk Analysis

HHS OIG Work Plan Summary Report Provider Focus

November 2020

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Prepared by SunHawk Consulting LLC

To our Compliance Colleagues and Partners:

SunHawk's review of OIG Audit statistics in 2020 found that compliance professionals and business risk owners experienced a 58% increase in HHS OIG audit activity over the prior year.[1] In an effort to promote the value of shared learnings, as well as give our colleagues and clients organized summaries of the over 250 active HHS OIG Work Plan items, SunHawk Consulting, LLC, has gathered, organized, and summarized the HHS OIG Work Plan for the Payer and Provider industries.

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

We review all OIG Work Plan items that we believe may have value for our partners. As a result, in addition to Payer and Provider-Focused Work Plan items, SunHawk has identified other audit items which we determined relevant to a limited number of Providers and Payers. We plan to publish a summary of these items in January 2021.

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.

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

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Provider

All Providers

[NEW] Audit of HRSA's Controls Over Medicare Providers' Compliance with the Attestation, Submitted-Revenue-Information, and Quarterly Use-of-Funds Reporting Requirements Related to the $50 Billion General Distribution of the Provider Relief Fund

Expected Issue Date: 2021
Announced/Revised: October 2020

A combined $175 billion in funding from the Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Paycheck Protection Program and Health Care Enhancement Act constitutes the Provider Relief Fund (PRF), which provides relief funds to hospitals and other health care providers for health-care-related expenses or lost revenue attributable to COVID-19 and to ensure that uninsured Americans can get testing and treatment for COVID-19. HHS allocated $50 billion for a General Distribution to Medicare providers. Providers that receive PRF funds are subject to certain requirements for attestation, submission of revenue information, and reporting of quarterly use-of-funds to HHS. A provider that received a PRF payment and retained it for at least 90 days without contacting HHS regarding the payment is deemed to have accepted its terms and conditions. Further, a provider must submit general revenue data after receiving or when applying to receive a payment. Finally, according to the CARES Act, Division B, Title V, Section 15011(b)(2), no later than 10 days after the end of each calendar quarter, a provider that received more than $150,000 in total funds for the coronavirus response and related activities shall submit a report to HHS regarding the use of those funds. As part of the OIG's oversight of the $50 billion General Distribution of the PRF, OIG will provide a snapshot of the effectiveness of the Health Resources and Services Administration's (HRSA's) controls over Medicare providers' compliance with the attestation, submitted-revenue-information, and quarterly use-of-funds reporting requirements. Specifically, OIG will review HRSA's internal controls and assess its policies and procedures related to these areas.

Work Plan #: W-00-21-59060
Government Program: Medicare Parts A & B

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Provider

Hospital

Swing-Bed Services at Nationwide Critical Access Hospitals

Expected Issue Date: 2021
Announced/Revised: August 2020

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

Work Plan #: W-00-20-35853
Government Program: Medicare Parts A & B

Audit of Medicare Payments for Inpatient Discharges Billed by Hospitals for Beneficiaries Diagnosed With COVID-19

Expected Issue Date: 2022
Announced/Revised: August 2020

Section 3710 of the Coronavirus Aid, Relief, and Economic Security Act directs the Secretary to increase the weighting factor that would otherwise apply to the assigned diagnosis-related group by 20 percent for an individual who is diagnosed with COVID-19 and discharged during the COVID-19 public health emergency period. OIG will audit whether payments made by Medicare for COVID-19 inpatient discharges billed by hospitals complied with Federal requirements.

Work Plan #: W-00-20-35856
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2021
Announced/Revised: August 2020

The Coronavirus Aid, Relief, and Economic Security (CARES) Act and the Pay check Protection Program and Health Care Enhancement Act appropriated $175 billion for the Provider Relief Fund (PRF) to support health care providers affected by the COVID-19 pandemic. In April 2020, the Health Resources and Services Administration began distributing the funds through general distributions to Medicare providers based on 2018 net patient revenue and targeted

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Provider

distributions for certain provider types (e.g., providers in areas particularly impacted by COVID-19, skilled nursing providers, and providers in rural areas). Providers such as hospitals may be eligible for PRF payments from the general and targeted distributions. OIG will select for audit a statistical sample of providers that received general and/or targeted distributions. OIG's objective is to determine whether providers that received PRF payments complied with certain Federal requirements, and the terms and conditions for reporting and expending PRF funds.

Work Plan #: W-00-20-35855
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2021
Announced/Revised: July 2020

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

Work Plan #: W-00-20-35854
Government Program: Accelerated and Advance Payment Program (AAP)

Hospital Collection Effort for Medicare Bad Debt Basic Health Program Eligibility Determinations

Expected Issue Date: 2021
Announced/Revised: July 2020

Medicare allows providers to claim reimbursement for a portion of these uncollectible deductibles and coinsurance once the provider establishes that reasonable collection efforts were made, that the debt was uncollectible, and that there was no likelihood of future recovery based on sound business judgment. Reasonable collection efforts can include billings, follow-up letters, phone calls, and personal contact. OIG plans to select a random sample of hospitals and review the policies and procedures in place related to collecting deductibles and coinsurance, offering financial assistance, identifying bad debt, and accounting for the receipt of previously reimbursed bad debt. In addition, OIG will select a judgmental sample of claims with high-dollar bad-debt amounts (coinsurance or deductible) and determine how the

hospitals adhered to federal criteria in treating these bad debts. OIG's audit will determine whether hospitals' policies and procedures for collecting Medicare deductible and coinsurance amounts from beneficiaries follow federal regulations for the reimbursement of bad debt.

Work Plan #: W-00-20-35849
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2021
Announced/Revised: Aug 2020

Coronavirus disease 2019 (COVID-19) can significantly tax hospitals and disproportionately affect Medicare beneficiaries. COVID-19 can affect much of a state or a locality at the same time, rapidly increasing the demand for hospital resources. Using Medicare claims data, this review will analyse the effects of COVID-19 on hospitalized Medicare beneficiaries and the hospital resources needed to care for them. Specifically, OIG will review utilization of the treatments provided and paid for by Medicare for patients with COVID-19 in selected localities that have known outbreaks. OIG will also describe the extent to which hospital utilization for Medicare beneficiaries changed over time.

Work Plan #: OEI-02-20-00410
Government Program: Medicare Parts A & B

Review of the Medicare DRG Window Policy

Expected Issue Date: 2021
Announced/Revised: May 2020

Outpatient services related to an inpatient admission are considered part of the inpatient payment and are not separately payable by Medicare. The diagnosis-related group (DRG) window policy defines when CMS considers outpatient services to be an extension of inpatient admissions, and generally includes services that are: (1) provided within the three days immediately preceding an inpatient admission to an acute-care hospital, (2) diagnostic services or admission-related non-diagnostic services, and (3) provided by the admitting hospital or by an entity wholly owned or operated by the admitting hospital. Building on previous OIG work, OIG will determine the number of admission-related outpatient services that were not covered by the DRG window policy in 2018, including services that were provided prior to the start of the DRG window and services that were provided at hospitals that shared a common owner. OIG will also determine the amounts that Medicare and beneficiaries would have saved in 2018 if the DRG window policy had been updated to include more days and other hospital ownership structures. In addition, OIG will interview CMS staff to identify other payment models that CMS could use to pay for outpatient services related to inpatient admissions.

Work Plan #: OEI-05-19-00380
Government Program: Medicare Parts A & B

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Behavioral Health

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Other Providers and Suppliers

Assessing Inpatient Hospital Billing for Medicare Beneficiaries

Expected Issue Date: 2021
Announced/Revised: May 2020

In 2016, hospitals billed Medicare $114 billion for inpatient hospital stays, accounting for 17 percent of all Medicare payments. The Centers for Medicare & Medicaid Services and the Office of Inspector General have identified problems with upcoding in hospital billing: the practice of mis- or over-coding to increase payment. OIG will conduct a two-part study to assess inpatient hospital billing. The first part will analyze Medicare claims data to provide landscape information about hospital billing. OIG will determine how inpatient hospital billing has changed over time and describe how inpatient billing varied among hospitals. OIG will then use the results of this analysis to target certain hospitals or codes for a medical review to determine the extent to which the hospitals billed incorrect codes.

Work Plan #: OEI-02-18-00380
Government Program: Medicare Parts A & B

CMS Oversight of Hospital Management of Networked Medical Device Security Through the Medicare Conditions of Participation

Expected Issue Date: 2021
Announced/Revised: May 2020

Networked medical devices are common and include infusion pumps, pacemakers, and diagnostic imaging equipment. These devices can be used to deliver care, transfer patient data, and/or remotely monitor patients. However, if hospitals do not have proper cybersecurity controls in place, the devices could be compromised, which could lead to adverse outcomes, such as loss of device functionality and patient harm. The Centers for Medicare & Medicaid Services' (CMS's) protocol for assessing hospitals' compliance with the Conditions of Participation (CoP) does not explicitly address cybersecurity practices for networked medical devices. It is unclear whether the survey protocols of accreditation organizations (AOs), which must meet or exceed those of CMS, evaluate cybersecurity when they review hospitals' compliance with the CoP. OIG will determine if any of the AOs address cybersecurity of networked medical devices when they assess compliance with accreditation requirements. For those that do, OIG will describe how they have done so and their experiences with hospitals. OIG will also identify any changes to their survey protocols that CMS or AOs are considering addressing cybersecurity of networked medical devices.

Work Plan #: OEI-01-20-00220
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2021
Announced/Revised: April 2020

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

Work Plan #: W-00-20-35845
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: March 2020

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

Work Plan #: W-00-20-35832
Government Program: Medicare Parts A & B

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Provider

Selected Inpatient and Outpatient Billing Requirements

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

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

Work Plan #: A-07-17-05102 (March 2020); A-04-17-08057 (October 2018); A-05-17-00026 (February 2018); A-04-17-08055 (February 2018); A-01-15-00515 (February 2018); A-05-16-00064 (January 2018); A-04-16-04049 (January 2018); A-05-16-00062 (November 2017); W-00-17-35538
Government Program: Medicare Parts A & B

Medicare Capital Payments to New Hospitals

Expected Issue Date: 2020
Announced/Revised: February 2020

Hospitals are reimbursed through Medicare Part A for Medicare-related capital costs (e.g., depreciation, interest, rent, and property-related insurance and taxes costs). New hospitals are paid on a cost basis for their first two years of operation. Beyond the first two years, hospitals' Medicare-related capital costs are paid through the inpatient prospective payments system under which a portion of their payment for each discharge is intended to cover capital costs. OIG will determine the potential impact for Medicare if capital payments to new hospitals were paid through the prospective payments system for the first two years.

Work Plan #: W-00-20-35843
Government Program: Medicare Parts A & B

Outpatient Outlier Payments for Short-Stay Claims

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

CMS makes an additional payment (an outlier payment) for hospital outpatient services when a hospital's charges, adjusted to cost, exceed a fixed multiple of the normal Medicare payment (Social Security Act (SSA) § 1833(t)(5)). The purpose of the outlier payment is to ensure beneficiary access to services by having Medicare share in the financial loss incurred by a provider associated with extraordinarily expensive individual cases. Prior OIG reports have concluded that hospitals' high charges, unrelated to cost, lead to excessive inpatient outlier payments. OIG will determine the extent of potential Medicare savings if hospital outpatient short stays (same day or over one midnight) were ineligible for an outlier payment. Prior to a nationwide review, OIG plans to perform several reviews at one or more hospitals to determine whether outpatient outlier payments to hospitals are associated with extraordinarily expensive individual cases.

Work Plan #: A-06-16-01002 (February 2020); W-00-16-35775
Government Program: Medicare Parts A & B

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Health-Care-Acquired Conditions - Prohibition on Federal Reimbursements

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

As of July 1, 2011, Federal payments to States are prohibited for any amounts expended for providing medical assistance for health-care-acquired conditions (SSA § 1903 and Patient Protection and Affordable Care Act § 2702). Federal regulations prohibit Medicaid payments by States for services related to health-care-acquired conditions and for provider preventable conditions as defined by Centers for Medicare & Medicaid Services or included in the Medicaid State Plan (42 CFR § 447.26). OIG will determine whether selected States made Medicaid payments for hospital care associated with health-care-acquired conditions and provider preventable conditions and quantify the amount of Medicaid payments for such conditions.

Work Plan #: A-06-16-01001 (October 2019); A-03-16-00205 (August 2019); A-02-16-01022 (May 2019); A-06-16-08004 (March 2018); A-07-16-03216 (May 2018); A-06-16-02003 (December 2018); W-00-16-31452
Government Program: Medicaid

Adverse Events in Hospitals: National Incidence Among Medicare Beneficiaries - 10-Year Update

Expected Issue Date: 2021
Announced/Revised: June 2019

OIG has conducted studies about adverse events (patient harm) in various healthcare settings since 2008, with 15 reports released or in process through 2019. The series includes a congressionally mandated study released in 2010 that found that 27 percent of Medicare beneficiaries experienced adverse events or temporary harm events while hospitalized in 2008. The current study will replicate the methodology used in the prior work for a sample of Medicare beneficiaries admitted to acute-care hospitals in 2018. OIG will measure the incidence of adverse events and temporary harm events, the extent to which the harms were preventable given better care, and the associated costs to Medicare. OIG will compare the 2018 results with the prior study results to assess progress in reducing harm at the 10-year mark, and identify differences in harm rates, types, contributing factors, preventability, and costs.

Work Plan #: OEI-06-18-00400
Government Program: Medicare Parts A & B

Comparison of Provider-Based and Freestanding Clinics

Expected Issue Date: 2020
Announced/Revised: June 2019

Provider-based facilities often receive higher payments for some services than freestanding clinics. OIG will review and compare Medicare payments for physician office visits in provider-based clinics and freestanding clinics to determine the

difference in payments made to the clinics for similar procedures. OIG will also assess the potential impact on Medicare and beneficiaries of hospitals' claiming provider-based status for such facilities.

Work Plan #: W-07-18-02815
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: January 2019

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

Work Plan #: W-00-19-35819
Government Program: Medicare Parts A & B

Medicare Payments for Overlapping Part A Inpatient Claims and Part B Outpatient Claims

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Overlapping claims can happen when a beneficiary is an inpatient of one hospital and then sent to another hospital to obtain outpatient services that are not available at the originating hospital. Certain items, supplies, and services furnished to inpatients are covered under Medicare Part A and should not be billed separately to Medicare Part B (42 CFR §§ 409.10 and 410.3; Medicare Claims Processing Manual, Ch. 3 § 10.4). Durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) claims for beneficiaries who received DMEPOS items while in an inpatient stay in a hospital should not be billed to Medicare separately. The payments associated with these claims are considered overpayments because Medicare does not allow separate payment for DMEPOS when a beneficiary is in a covered inpatient stay (Medicare Claims Processing Manual, Ch. 20 § 01). OIG will review the CMS Common Working File (CWF) edits that should deny claims for DMEPOS items furnished during an inpatient stay. Prior OIG reviews and investigations have

identified this area as at risk for noncompliance with Medicare billing requirements. OIG will review Medicare payments to certain types of inpatient hospitals to determine whether claims billed to Part B for certain items, supplies, and services provided during inpatient stays were made in accord with Federal requirements.

Work Plan #: A-09-17-03035 (November 2018); A-09-16-02026 (September 2017); W-00-16-35752
Government Program: Medicare Parts A & B

Hospitals' Compliance with Medicare's Transfer Policy with the Resumption of Home Health Services and the Use of Condition Codes

Expected Issue Date: 2020
Announced/Revised: August 2018

Medicare payments to acute care hospitals for inpatient stays under Medicare Part A are made based on prospectively set rates. Normally, Medicare pays a hospital discharging a beneficiary the full amount for the corresponding diagnosis-related group (DRG). In contrast, a hospital that transfers a beneficiary to another facility or to home health services is paid a graduated per diem rate, not to exceed the full DRG payment. When transferring a patient to home health services, the hospital can apply specific condition codes to the claim and receive the full DRG payment. The hospital is responsible for coding the bill based on its discharge plan for the patient or adjusting the claim if it finds out that the patient received post-acute care after the discharge. OIG will determine whether Medicare appropriately paid hospitals' inpatient claims subject to the post-acute care transfer policy when: (1) patients resumed home health services after discharge or (2) hospitals applied condition codes to claims to receive a full DRG payment.

Work Plan #: W-00-18-35815
Government Program: Medicare Parts A & B

Hospitals Billing for Severe Malnutrition on Medicare Claims

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Many elderly Medicare patients, especially those who are severely ill, are malnourished. Malnutrition can result from the treatment of another condition, inadequate treatment or neglect, or the general deterioration of a patient's health. Medicare sets forth a number of Federal requirements, including the Social Security Act § 1862(a)(1)(A), related to billing for the treatment of severe malnutrition. Hospitals are allowed to bill for the treatment of malnutrition on the basis of the severity of the conditions; mild, moderate, or severe, and whether it affects patient care. Severe malnutrition is classified as a major complication or comorbidity (MCC). Adding an MCC to a Medicare claim can result in a higher Medicare payment because the claim is coded at a higher Diagnosis Related Group. This review will assess the accuracy of Medicare payments for the treatment of severe malnutrition. OIG will determine whether providers are complying with Medicare billing requirements when assigning diagnosis codes for the treatment of severe types of malnutrition on inpatient hospital claims.

Work Plan #: A-03-17-00005 (June 2018); W-00-17-35804
Government Program: Medicare Parts A & B

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Provider

Payment Credits for Replaced Medical Devices That Were Implanted

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Certain medical devices are implanted during inpatient or outpatient procedures. Such devices may require replacement because of defects, recalls, mechanical complication, and other factors. Under certain circumstances, Federal regulations require reductions in Medicare payments for inpatient, outpatient, and ambulatory surgical center (ASC) claims for the replacement of implanted devices due to recalls or failures (42 CFR §§ 412.89, 419.45, and 416.179). Prior OIG reviews have determined that Medicare administrative contractors made improper payments to hospitals for inpatient and outpatient claims for replaced medical devices. OIG will determine whether Medicare payments for replaced medical devices were made in accord with Medicare requirements.

Work Plan #: A-05-16-00059 (March 2018); W-00-16-35745; W-00-18-35745
Government Program: Medicare Parts A & B

Nationwide Medicare Electronic Health Record Incentive Payments to Hospitals

Expected Issue Date: 2020
Announced/Revised: July 2017

Medicare incentive payments were authorized over a five-year period to hospitals that adopted electronic health record (EHR) technology (Recovery Act, 4102). From January 1, 2011, through December 31, 2016, the Centers for Medicare & Medicaid Services (CMS) made Medicare EHR incentive payments to hospitals totaling $14.6 billion. The Government Accountability Office identified improper incentive payments as the primary risk to the Medicare EHR incentive program. A Department of Health and Human Services, Office of Inspector General (OIG) report describes the obstacles that CMS faces in overseeing the Medicare EHR incentive program. In addition, previous OIG reviews of Medicaid EHR incentive payments found that state agencies overpaid hospitals by $66.7 million and would in the future overpay these hospitals an additional $13.2 million. These overpayments resulted from inaccuracies in the hospitals calculations of total incentive payments. OIG will review hospital incentive payment calculations to identify potential overpayments that the hospitals would have received as a result of the inaccuracies.

Work Plan #: W-00-17-35795; A-09-17-03020
Government Program: Medicare Parts A & B

Review of Medicare Payments for Nonphysician Outpatient Services Provided Under the Inpatient Prospective Payment System

Expected Issue Date: 2020
Announced/Revised: July 2017

Under the Medicare Part A inpatient prospective payment system (IPPS), hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries, as long as the beneficiary has at least one benefit day at the time of admission. The prospective payment amount represents the total Medicare payment for the inpatient operating costs associated with a beneficiary's hospital stay. Inpatient operating costs include routine services,

ancillary services (e.g., radiology and laboratory services), special care unit costs, malpractice insurance costs, and preadmission services. Accordingly, hospitals generally receive no additional payments for nonphysician outpatient services furnished shortly before and during inpatient stays. Medicare makes a duplicate payment if it makes a separate Part B payment to providers for such nonphysician outpatient services. Prior Office of Inspector General reviews identified significant overpayments to hospital outpatient providers for nonphysician services furnished shortly before or during inpatient stays. OIG recent work indicated that providers are still billing inappropriately, and contractors continue to make inappropriate payments for these nonphysician outpatient services. Additionally, Medicare payment system controls are not preventing or detecting overpayments for incorrectly billed services. OIG's objective is to determine whether nationwide Medicare payments to hospital outpatient providers were correct for nonphysician outpatient services provided within three days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge).

Work Plan #: W-00-17-35799; A-01-17-00508
Government Program: Medicare Parts A & B

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Provider

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Provider

Long Term Care

State Compliance with Requirements for Reporting and Monitoring Critical Incidents

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

The Centers for Medicare & Medicaid Services requires states to implement an incident reporting system to protect the health and welfare of the Medicaid beneficiaries who receive services in community-based settings or nursing facilities. During prior audits, OIG found that some states did not always comply with federal and state requirements for reporting and monitoring critical incidents such as abuse and neglect. OIG will review additional State Medicaid Agencies to determine whether the selected states follow the requirements for reporting and monitoring critical incidents. OIG's work will focus on Medicaid beneficiaries residing in both community-based settings and nursing facilities.

Work Plan #: A-04-17-04063 (July 2020); A-03-17-00202 (January 2020); A-09-17-02006 (June 2019); W-00-17-31040; A-02-17-01026; A-04-17-03084; A-04-17-08058; A-06-17-01003; A-06-17-02005; A-06-17-04003
Government Program: Medicaid

Meeting the Challenges Presented by COVID-19: Nursing Homes

Expected Issue Date: 2021
Announced/Revised: June 2020

The coronavirus disease 2019 (COVID-19) pandemic has created unprecedented challenges for nursing homes. These challenges include procuring critical supplies, testing residents and staff, isolating high numbers of contagious residents, caring for those afflicted, and protecting staff on a scale never experienced in this country. This nationwide, two-part study on nursing homes will examine how the COVID-19 pandemic has affected nursing homes. The first part will describe the characteristics of the nursing homes that were hardest hit by the pandemic (i.e. homes with high numbers of residents who had COVID-19 or had died). The second part will describe the strategies nursing homes have used to mitigate the effects of COVID-19 on their residents and staff in the face of these unique circumstances.

Work Plan #: OEI-02-20-00490
Government Program: Medicare Parts A & B

Audit of Nursing Homes' Reporting of COVID-19 Information Under CMS's New Requirements

Expected Issue Date: 2021
Announced/Revised: June 2020

In response to the coronavirus disease 2019 (COVID-19) public health emergency, CMS added requirements to an existing regulation that requires nursing homes to report to state and local health departments communicable diseases, health care-associated infections, and potential outbreaks. Under one requirement, these facilities must now report COVID-19 data (such as information on suspected and confirmed infections, and deaths among residents and staff) to the Centers for Disease Control and Prevention through its National Healthcare Safety Network system. The data must be

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reported in a standardized format at least weekly. OIG will assess nursing homes' reporting of CMS-required information related to the COVID-19 public health emergency. Specifically, OIG will determine whether the data reported by nursing homes were complete, accurate, and reliable.

Work Plan #: W-00-20-31546
Government Program: Medicare Parts A & B

Involuntary Transfer and Discharge in Nursing Homes

Expected Issue Date: 2021
Announced/Revised: May 2020

The involuntary transfer or discharge of a resident of a nursing home can be unsafe and a traumatic experience for the resident and his or her family. To address these concerns, Congress passed the Nursing Home Reform Act of 1987 to protect residents against involuntary transfer and discharge. However, data from the National Ombudsman Reporting System show that from 2011 through 2016, the Long-Term Care Ombudsman Program, established to advocate for older Americans by the Older Americans Act of 1965, cited complaints related to "discharge/eviction" more frequently than any other concern. In addition, the media has recently highlighted the rise in nursing home evictions. CMS estimates that as many as one-third of all residents in long-term care facilities are involuntarily discharged. OIG will determine the extent to which State long-term care ombudsmen address involuntary transfers and discharges from nursing homes and the extent to which State survey agencies investigated and took enforcement actions against nursing homes for inappropriate involuntary transfers and discharges. OIG will also examine the extent to which nursing homes meet CMS requirements for involuntary transfers and discharges.

Work Plan #: OEI-01-18-00250
Government Program: Medicare Parts A & B

Monitoring Psychotropic Drug Use in Nursing Homes

Expected Issue Date: 2021
Announced/Revised: May 2020

Previous OIG work found that elderly nursing home residents who were prescribed antipsychotics, a type of psychotropic drug, were at risk for harm. In response, the Centers for Medicare & Medicaid Services (CMS) took steps to address the risk of harm to nursing home residents. One such step was introducing a quality measure to track the rates of antipsychotic drug use in residents without an appropriate diagnosis. Recently, CMS and researchers expressed concerns that some nursing homes underreport antipsychotic drug use and may inaccurately report certain patient diagnoses in order to avoid CMS monitoring. Additionally, research on antipsychotic drug use has highlighted the need to closely monitor all psychotropic drug use to accurately oversee drug use in nursing homes. OIG will determine the extent to which there are inconsistencies, if any, between: (1) Medicare claims data for residents prescribed psychotropic drugs compared to nursing home self-reported data on residents who received psychotropic drugs, and (2) Medicare claims data as it relates to the diagnoses that exclude residents from monitoring in the antipsychotic quality measure compared to nursing home self-reported data on resident diagnoses.

Work Plan #: OEI-07-19-00490
Government Program: Medicare Parts A & B

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Provider

Nursing Facility Staffing: Reported Levels and CMS Oversight

Expected Issue Date: 2021
Announced/Revised: May 2020

Staffing levels in nursing facilities can impact residents' quality of care. Nursing facilities that receive Medicaid and Medicare payments must provide sufficient licensed nursing services 24 hours a day, including a registered nurse for at least 8 consecutive hours every day. CMS uses auditable daily staffing data, called the Payroll-Based Journal, to analyze staffing patterns and populate the staffing component of the Nursing Home Compare website a site that enables the public to compare the results of health and safety inspections, the quality of care provided at nursing facilities, and staffing at nursing facilities. The first of two reports will be a data brief that describes nursing staffing levels reported by facilities to the Payroll-Based Journal. The second report will examine CMS's efforts to ensure data accuracy and improve resident quality of care.

Work Plan #: OEI-04-18-00451
Government Program: Medicare Parts A & B

Audit of Nursing Home Infection Prevention and Control Program Deficiencies

Expected Issue Date: 2020
Announced/Revised: May 2020

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

Work Plan #: W-00-20-31545
Government Program: Medicare Parts A & B

Nursing Home Oversight During the COVID-19 Pandemic

Expected Issue Date: 2020
Announced/Revised: May 2020

Onsite surveys of nursing homes are a fundamental safeguard to ensure that nursing home residents are safe and receive high-quality care. In response to the coronavirus disease 2019 (COVID-19) pandemic, CMS directed State Survey Agencies (SSAs) to suspend standard onsite surveys and most onsite surveys for complaints. CMS directed SSAs to conduct onsite surveys in response to the most serious complaints (i.e., those involving immediate jeopardy) and complaints related to infection control, and to conduct targeted infection control surveys, which are abbreviated surveys focused on infection control policies and practices within facilities. Using recent complaint and survey data for all nursing homes, this study will examine the extent to which SSAs and CMS are conducting onsite surveys in nursing homes related to serious complaints and targeted infection control, in accord with CMS's recent guidance to suspend certain

onsite surveys. OIG will also identify any barriers that CMS and SSAs face in conducting onsite surveys, as well as potential solutions.

Work Plan #: OEI-01-20-00430
Government Program: Medicare Parts A & B

Nursing Homes: CMS Oversight of State Survey Agencies

Expected Issue Date: 2021
Announced/Revised: May 2020

CMS enters into agreements with State Survey Agencies (SAs) to conduct surveys to determine whether nursing homes are compliant with Medicare requirements. Recent reports by OIG found problems in SA performance, including not verifying whether nursing homes corrected deficiencies and not investigating complaints in a timely manner. CMS evaluates SA performance in fulfilling their surveying responsibilities, including through federal monitoring surveys and performance thresholds described in the State Performance Standards System. When there is inadequate SA performance, CMS may impose a sanction or remedy, such as providing for training of survey teams, requiring the SA to submit a corrective action plan, or reducing the state's allotment of Federal financial participation. OIG will describe CMS's efforts to work with SAs to improve performance by conducting interviews and reviewing supporting documentation about CMS's monitoring efforts. OIG will also identify any challenges or barriers that may impede CMS's ability to help SAs improve performance.

Work Plan #: OEI-06-19-00460
Government Program: Medicare Parts A & B

Medicaid Nursing Home Life Safety and Emergency Preparedness Reviews

Expected Issue Date: 2020
Announced/Revised: March 2020

Previous OIG audits on Medicaid nursing home life safety and emergency preparedness have identified multiple issues that put vulnerable populations at risk and indicated that nursing homes in various states are not complying with these requirements. In 2016, CMS updated its health care facilities' life safety and emergency preparedness requirements to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term-care (LTC) facilities. In addition, in 2019 CMS also issued expanded guidance on emerging infectious disease control to ensure that health care facilities are prepared to respond to threats from infectious diseases. OIG is reviewing this area because residents of LTC facilities are particularly vulnerable to risks such as fires, natural disasters, or disease outbreak (such as COVID-19 and other coronaviruses). OIG's objective is to determine whether LTC facilities that received Medicare or Medicaid funds complied with new federal requirements for life safety and emergency and infectious disease control preparedness.

Work Plan #: W-00-20-31525
Government Program: Medicaid

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Provider

Medicaid Nursing Home Life Safety Reviews

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

CMS recently updated its health care facilities' life safety and emergency preparedness requirements to improve protections for all Medicare and Medicaid beneficiaries, including those residing in LTC facilities. These updates include requirements that facilities install expanded sprinkler and smoke detector systems to protect residents from the hazards of fire and develop an emergency preparedness plan that facilities must review, test, update, and train residents on annually. The plan must include provisions for sheltering in place and evacuation. OIG is reviewing this area because residents of LTC facilities are particularly vulnerable to the risk of fires since many of these residents have limited or no mobility. OIG's objective is to determine if LTC facilities that received Medicare or Medicaid funds complied with new Federal requirements for life safety and emergency preparedness for the period May 4, 2016, through November 15, 2017.

Work Plan #: A-02-17-01027 (August 2019); W-00-17-31525
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: August 2019

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

Work Plan #: W-00-19-35824
Government Program: Medicare Parts A & B

Medicaid Assisted Living Services

Expected Issue Date: 2020
Announced/Revised: August 2019

Medicaid may provide assisted living services to beneficiaries who are medically eligible for placement in a nursing home but opt for a less medically intensive, lower-cost setting. These services may include personal care (e.g., assistance with dressing and bathing), homemaker services (e.g., housecleaning and laundry), personal emergency response services, and therapy services (i.e., physical, speech, and occupational). A 2018 Government Accountability Office report indicated that improved Federal oversight of beneficiary health and welfare is needed in States' administration of Medicaid assisted living services. OIG will determine whether assisted living providers are meeting quality-of-care requirements for Medicaid

beneficiaries residing in assisted living facilities and whether the providers properly claimed Medicaid reimbursement for services in accordance with Federal and State requirements.

Work Plan #: W-00-19-31541
Government Program: Medicaid

Post-Hospital Skilled Nursing Facility Care Provided to Dually Eligible Beneficiaries

Expected Issue Date: 2020
Announced/Revised: March 2019

Skilled nursing facilities (SNFs) are specially qualified facilities that provide extended care services, such as skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. During previous OIG reviews, OIG noted that some nursing facility residents who were receiving Medicaid-covered nursing home care were admitted to a hospital and returned to the same facility to receive Medicare-covered post-hospital SNF care. In some cases, hospital physicians discharged beneficiaries to "home" rather than "SNF," yet nursing facility physicians certified that skilled care was needed. Because Medicare pays substantially more for SNF care than Medicaid for nursing home care, nursing facilities have financial incentives to increase the level of care to "skilled." OIG will determine whether the post-hospital SNF care provided to dually eligible beneficiaries met the level of care requirements. Specifically, OIG will determine whether: (1) the SNF level of care was certified by a physician (e.g., a hospital or SNF physician) or a physician extender (i.e., a nurse practitioner, clinical nurse specialist, or physician assistant); (2) the condition treated at the SNF was a condition for which the beneficiary received inpatient hospital services or a condition that arose while the beneficiary was receiving care in a SNF for a condition for which the beneficiary received inpatient hospital services; (3) daily skilled care was required; (4) the services delivered were reasonable and necessary for the treatment of a beneficiary's illness or injury; and (5) improper Medicare payments were made on the claims OIG review. OIG will also determine whether any of the hospital admissions OIG review were potentially avoidable.

Work Plan #: W-00-19-35821
Government Program: Medicare Parts A & B

Skilled Nursing Facility Reimbursement

Expected Issue Date: 2020
Announced/Revised: November 2016

Some SNF patients require total assistance with their activities of daily living and have complex nursing and physical, speech, and occupational therapy needs. SNFs are required to periodically assess their patients using a tool called the Minimum Data Set that helps classify each patient into a resource utilization group for payment. Medicare payment for SNF services varies based on the activities of daily living score and the therapy minutes received by the beneficiary and reported on the Minimum Data Set. The more care and therapy the patient requires, the higher the Medicare payment. Previous OIG's work found that SNFs are billing for higher levels of therapy than were provided or were reasonable or necessary. OIG will review the documentation at selected SNFs to determine if it meets the requirements for each resource utilization group.

Work Plan #: W-00-16-35784

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Provider

Government Program: Medicare Parts A & B

Managed Long-Term-Care Reimbursements

Expected Issue Date: 2020
Announced/Revised: November 2016

Medicaid managed care plans are subject to federal requirements. Some states contract with MCOs to provide long-term services. OIG will review states' reimbursements made to managed long-term-care plans to determine whether those reimbursements complied with certain federal and state requirements.

Work Plan #: W-00-17-31510
Government Program: Medicaid

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Provider

Home Health Service

Infection Control at Home Health Agencies During the COVID-19 Pandemic

Expected Issue Date: 2021
Announced/Revised: September 2020

The coronavirus that causes the respiratory disease COVID-19 is especially dangerous for adults aged 65 years and older and those with underlying medical conditions. Medicare beneficiaries receiving home health services may be at a high risk of developing severe illness from COVID-19. Home health services are covered for the elderly and disabled under the Medicare program. Home health services may include skilled nursing care, physical therapy, speech-language pathology, occupational therapy, and medical supplies. Home health agencies (HHAs) must meet certain requirements to participate in the Medicare and Medicaid programs, including meeting infection prevention and control standards. On March 10, 2020, CMS issued a State Survey Directors Letter, "Guidance for Infection Control and Prevention Concerning Coronavirus Disease 2019 (COVID-19) in Home Health Agencies (HHAs)," to provide HHAs with guidance on addressing the outbreak and minimizing transmission. Home health workers often travel to several homes on a weekly basis, which increases their risk of exposure to the COVID-19 and increases the risk of infection among Medicare beneficiaries. HHAs must maintain a coordinated agencywide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. OIG will interview corporate officers from the three HHA providers with the largest market share in 2019 as well as HHAs that have recently been cited by CMS for infection control and prevention deficiencies to determine the extent to which their infection control and prevention policy and procedures comply with CMS guidance regarding COVID-19.

Work Plan #: W-00-20-35858
Government Program: Medicare Parts A & B

Analysis of New Rural Add-On Payment Methodology

Expected Issue Date: 2021
Announced/Revised: July 2020

Section 50208 of the Bipartisan Budget Act of 2018 (the BBA) extended rural add-on payments for home health episodes and visits ending during calendar years (CYs) 2019 through 2022, and mandated implementation of a new methodology for applying those payments. Beginning in CY 2019, rural add-on payments were provided in varying amounts according to classification in one of three rural categories: (1) high utilization; (2) low population density; and (3) all other. The BBA requires home health claims to indicate the code for the county in which the home health service is provided. CMS has instructed providers to use value code 85 to report the county code and will return claims for correction when the code is missing or invalid. The BBA also mandated that, no later than January 1, 2023, HHS-OIG submit to Congress an analysis of Medicare home health claims and utilization of home health services by county (or equivalent area) and recommendations, as appropriate, based on such analysis. To meet that mandate, OIG will perform an analysis of Medicare home health claims for CYs 2019 through 2021. OIG will trend the claim data and cost reports to determine

Provider

what impact, if any, the new rural add-on methodology has had on home health agency providers and the utilization of home health services in rural areas.

Work Plan #: W-00-20-35850
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2021
Announced/Revised: April 2020

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

Work Plan #: W-00-20-31543
Government Program: Medicaid

Medicaid Health Home Services for Beneficiaries with Chronic Conditions

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Section 1945 of the Social Security Act created an optional Medicaid State Plan benefit for States to establish "health homes" to coordinate care for people with Medicaid who have chronic medical conditions. States receive a 90-percent enhanced Federal Medical Assistance Percentage (FMAP) for health home services valid through the first eight quarters of the program. The State option to provide health home services to eligible Medicaid beneficiaries became effective on January 1, 2011. As of May 2017, CMS has approved Medicaid State plan amendments for 21 States and the District of Columbia for health home programs. More than 1 million Medicaid beneficiaries have been enrolled in these programs. OIG will review Medicaid health home programs for compliance with relevant Federal and State requirements.

Work Plan #: A-02-17-01004 (July 2019); W-00-17-31524; A-02-17-00000
Government Program: Medicaid

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Provider

- All Providers
- Hospital
- Long Term Care
- Home Health Service
- Hospice
- Medical Equipment & Supplies
- Physical and Other Therapies
- Accountable Care Organizations
- Behavioral Health
- Laboratory
- Prescriber
- Telehealth
- Other Providers and Suppliers

Home Health Compliance with Medicare Requirements

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

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

Work Plan #: A-02-16-01001 (May 2019); A-05-16-00057 (May 2019); A-05-16-00055 (May 2019); A-01-16-00500 (May 2019); A-07-16-05092 (August 2019); A-07-16-05093 (October 2019); A-05-17-00022 (December 2019); W-00-19-35712; W-00-16-35712; W-00-16-35501; W-00-17-35712; various reviews
Government Program: Medicare Parts A & B

Medicaid Personal Care Services

Expected Issue Date: 2020
Announced/Revised: April 2019

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

Work Plan #: W-00-19-31536
Government Program: Medicaid

Health and Safety Standards in Social Services for Adults

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

State agencies operate elderly waiver programs under a 1915(c) waiver to their Medicaid State plan. Adult day centers are center-based facilities directly licensed by the State agency. They provide adult day services to functionally impaired adults on a regular basis for periods of fewer than 24 hours during the day in a nonresidential setting. As the licensing agency for adult day care centers, the State agency must ensure that adult day centers follow applicable licensing standards to protect the health and safety of adults receiving services at these facilities. Recent OIG reports have

Provider

identified numerous instances of noncompliance in regulated childcare facilities and family adult foster care homes. OIG will determine whether regulated adult day centers comply with applicable Federal, State, and local regulations and standards on ensuring the health and safety of adults in their care, including infection control for conditions such as coronavirus disease 2019 (COVID-19) and other coronaviruses.

Work Plan #: A-05-16-00044 (October 2018); A-05-17-00030 (October 2018); A-05-17-00009; A-05-17-00028; W-00-20-31503
Government Program: Medicaid

Review of Home Health Claims for Services with Five to Ten Skilled Visits

Expected Issue Date: 2020
Announced/Revised: June 2018

If a home health agency (HHA) provides four or fewer visits from a skilled service provider that are included under home health coverage (excluding visits providing only services listed in 42 CFR § 409.49) in an episode, the HHA will be paid a standardized per-visit payment based on visit type. Such payment adjustments, and the episodes themselves, are called Low Utilization Payment Adjustments (LUPA). Once a fifth visit is provided, an HHA will instead receive a full 60-day payment based on episode of care. Since OIG has not reviewed payments for LUPA, OIG will review supporting documentation to determine whether home health claims with five to ten skilled visits in a payment episode in which the beneficiary was discharged home met the conditions for coverage and were adequately supported as required by federal guidance.

Work Plan #: W-00-18-35813
Government Program: Medicare Parts A & B

Consumer-Directed Personal Assistance Program

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

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

Work Plan #: A-02-16-01026 (June 2018); W-00-16-31035;
Government Program: Medicaid

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Provider

Hospice

Medicare Payments Made Outside of the Hospice Benefit

Expected Issue Date: 2020
Announced/Revised: June 2018

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

Work Plan #: W-00-17-35797, W-00-18-35797
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: November 2016

In 2013, more than 1.3 million Medicare beneficiaries received hospice services from more than 3,900 hospice providers, and Medicare hospice expenditures totaled $15.1 billion. Hospices are required to comply with all Federal, State, and local laws and regulations related to the health and safety of patients (42 CFR § 418.116). Medicare requires that a registered nurse make an on-site visit to the patient's home at least once every 14 days to assess the quality of care and services provided by the hospice aide and to ensure that services ordered by the hospice interdisciplinary group meet the patient's needs (42 CFR § 418.76(h)(1)(i)). OIG will determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.

Work Plan #: W-00-16-35777
Government Program: Medicare Parts A & B

Provider

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

Review of Hospices' Compliance with Medicare Requirements

Expected Issue Date: 2020
Announced/Revised: November 2016

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

Work Plan #: W-00-16-35783; various reviews
Government Program: Medicare Parts A & B

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Provider

Medical Equipment & Supplies

Review of Medicare Payments for Power Mobility Device Repairs

Expected Issue Date: 2020
Announced/Revised: October 2019

Medicare Part B covers medically necessary power mobility devices (PMDs), such as power wheelchairs, and PMD repairs that are reasonable and necessary to make the equipment serviceable. For calendar year 2018, Medicare Part B paid approximately $46.7 million for PMD repairs, including replacement parts needed to repair PMDs. Durable medical equipment (DME) suppliers must maintain documentation from the physician or treating practitioner indicating that the PMD being repaired continued to be medically necessary and that the repairs were reasonable and necessary. DME suppliers must also maintain detailed records describing the need for and nature of all repairs, which includes a justification for the replaced parts and the labor time. In addition, if the expense for repairs exceeds the estimated expense of purchasing or renting another PMD for the remaining period of medical need, no payment can be made for the excess. OIG will audit Medicare payments for PMD repairs to determine whether suppliers complied with Medicare requirements.

Work Plan #: W-00-19-35828
Government Program: Medicare Parts A & B

Supplier Compliance with Medicare Requirements for Replacement of Positive Airway Pressure Device Supplies

Expected Issue Date: 2020
Announced/Revised: October 2019

Beneficiaries receiving continuous positive airway pressure or respiratory assist device (collectively known as positive airway pressure (PAP) devices) therapy require replacement of supplies (e.g., mask, tubing, headgear, and filters) when they wear out or are exhausted. Medicare payments for these replacement supplies in 2017 and 2018 were approximately $945.8 million. Prior OIG work found that most Medicare claims that suppliers submitted for replacement PAP device supplies did not comply with Medicare requirements. For supplies and accessories used periodically, orders must specify the type of supplies needed, the frequency of use, if applicable, and the quantity to be dispensed, and suppliers must not automatically ship refills on a predetermined basis. OIG will review claims for frequently replaced PAP device supplies at selected suppliers to determine whether documentation requirements for medical necessity, frequency of replacement and other Medicare requirements are met.

Work Plan #: W-00-20-35830
Government Program: Medicare Parts A & B

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Provider

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

Expected Issue Date: 2020
Announced/Revised: August 2019

An OIG analysis of the 2017 Comprehensive Error Rate Testing (CERT) program for positive airway pressure (PAP) device payments shows potential overpayments of $566 million. Claims for PAP devices used to treat obstructive sleep apnea (OSA) for beneficiaries who have not had a positive diagnosis of OSA based on an appropriate sleep study are not reasonable and necessary. OIG will examine Medicare payments to durable medical equipment providers for PAP devices used to treat OSA to determine whether an appropriate sleep study was conducted.

Work Plan #: W-00-19-35823
Government Program: Medicare Parts A & B

Orthotic Braces - Supplier Compliance with Payment Requirements

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Medicare requires that suppliers claims for DMEPOS be "reasonable and necessary" (SSA § 1862(a)(1)(A)). Further, local coverage determinations issued by the four Medicare contractors that process DMEPOS claims include utilization guidelines and documentation requirements for orthotic braces. Prior OIG work indicated that some DMEPOS suppliers were billing for services that were medically unnecessary (e.g., beneficiaries receiving multiple braces and referring physician did not see the beneficiary) or were not documented in accordance with Medicare requirements. OIG will review Medicare Part B payments for orthotic braces to determine whether they were medically necessary and were supported in accordance with Medicare requirements.

Work Plan #: A-09-17-03030 (January 2019); A-09-17-03027 (December 2018); W-00-17-35749
Government Program: Medicare Parts A & B

Positive Airway Pressure Device Supplies - Supplier Compliance with Documentation Requirements for Frequency and Medical Necessity

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Beneficiaries receiving continuous positive airway pressure or respiratory assist device therapy (PAP) require replacement of the device's supplies (e.g. mask, tubing, headgear, and filters) when they wear out or are exhausted. Medicare payments for these supplies in 2014 and 2015 were approximately $953 million. Prior OIG work found that suppliers automatically shipped PAP device supplies when no physician orders for refills were in effect. For supplies and accessories used periodically, orders or certificates of medical necessity must specify the type of supplies needed and the frequency with which they must be replaced, used, or consumed (Centers for Medicare & Medicaid Services's Medicare Program Integrity Manual, Pub. 100-08, Ch. 5, §§ 5.2.3 and 5.9). Beneficiaries or their caregivers must specifically request refills of repetitive services and/or supplies before suppliers dispense them (Centers for Medicare & Medicaid Services, Medicare Claims Processing Manual, Pub. 100-04, Ch. 20, § 200). OIG will review claims for frequently

replaced PAP device supplies to determine whether documentation requirements for medical necessity, frequency of replacement, and other Medicare requirements are met. (W-00-16-35240; W-00-17-35787)

Work Plan #: A-04-17-04056 (June 2018); W-00-17-35787
Government Program: Medicare Parts A & B

Non-invasive Home Ventilators - Compliance with Medicare Requirements

Expected Issue Date: 2020
Announced/Revised: May 2018

For items such as non-invasive home ventilators (NHVs) and respiratory assist devices (RADs) to be covered by Medicare, they must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. Depending on the severity of the beneficiary's condition, an NHV or RAD may be reasonable and necessary. NHVs can operate in several modes, i.e., traditional ventilator mode, RAD mode, and basic continuous positive airway pressure (CPAP) mode. The higher cost of the NHVs' combination of non-invasive interface and multimodal capability creates a greater risk that a beneficiary will be provided an NHV when a less expensive device such as a RAD or CPAP device is warranted for the patient's medical condition. Prior OIG work identified significant growth in Medicare billing for NHVs in the years since they reached the market. OIG will determine whether claims for NHVs were medically necessary for the treatment of beneficiaries' diagnosed illnesses and whether the claims complied with Medicare payment and documentation requirements.

Work Plan #: W-00-18-35809
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: August 2017

Medicare reimbursement for ventilation devices has risen from $51 million in 2011 to $72 million in 2015. However, unlike similar items for which Medicare has seen reduced costs through competitive bidding, ventilation devices have not been competitively bid. OIG will determine the reasonableness of the fee schedule prices that Medicare and beneficiaries pay for ventilation devices compared to prices on the open market to identify potential wasteful spending in the Medicare program.

Work Plan #: W-00-17-35803; A-05-xx-xxxxx
Government Program: Medicare Parts A & B

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Provider

Physical and Other Therapies

Medicare Part B Payments for Speech-Language Pathology

Expected Issue Date: 2020
Announced/Revised: October 2019

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

Work Plan #: W-00-19-35827
Government Program: Medicare Parts A & B

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Provider

Accountable Care Organizations

Review of Quality Measures Data Reported by Accountable Care Organizations in the Medicare Shared Savings Program

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

The Medicare Shared Savings Program (MSSP) was established by section 3022 of the Patient Protection and Affordable Care Act to facilitate coordination and cooperation among providers, improve quality of care for Medicare fee-for-service beneficiaries, and reduce unnecessary costs. Eligible providers and suppliers may voluntarily participate in the MSSP by creating or joining an Accountable Care Organization (ACO). ACOs that lower health care costs and meet quality performance standards for their beneficiary populations are eligible to share in any savings that the ACOs generate for the Medicare program (earned shared savings). To demonstrate that they are providing appropriate, high-quality care while reducing costs, ACOs are required to report complete and accurate data on quality measures and to satisfy minimum levels of certain quality measures as set by CMS. CMS assesses an ACO's overall quality performance by calculating a single quality performance score across all quality measures reported by the ACO. This score is used in part to calculate the ACO's earned shared savings. OIG will review MSSP ACOs that received earned shared savings payments to determine whether they reported quality measures data in accordance with Federal requirements. OIG's review is part of several OIG reviews that will examine various aspects of the ACOs under the MSSP.

Work Plan #: A-09-17-03023; W-00-18-35798
Government Program: Medicare Parts A & B

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Provider

Behavioral Health

Use of Telehealth to Provide Behavioral Health Services in Medicaid Managed Care

Expected Issue Date: 2021
Announced/Revised: May 2020

Telehealth is the use of telecommunications and information technology to provide access to health assessment, diagnosis, intervention, consultation, supervision, and information across distance. Telehealth can increase beneficiaries' access to healthcare and reduce healthcare spending. All 50 States and the District of Columbia currently provide some coverage under Medicaid of telehealth; however, limited information is available about how states use telehealth to provide behavioral health services to Medicaid managed care enrollees. This review will focus on selected states and will analyze how these states and managed care organizations (MCOs) use telehealth to provide behavioral healthcare. It will also review selected states' monitoring and oversight of MCOs' behavioral health services provided via telehealth. Finally, it will identify states' and MCOs' practices on how to maximize the benefits and minimize the risks of providing behavioral healthcare via telehealth.

Work Plan #: OEI-02-19-00400
Government Program: Medicaid

Medicaid Claims for Opioid Treatment Program Services

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Medicaid is a significant source of coverage and funding for behavioral health treatment services, including treatment of substance abuse. Some Medicaid State agencies provide payment for Opioid Treatment Program (OTP) services. Services can be provided at freestanding and hospital-based OTPs. OIG will determine whether selected state agencies complied with certain federal and state requirements when claiming Medicaid reimbursement for OTP services.

Work Plan #: A-02-17-01021 (February 2020); W-00-17-31523
Government Program: Medicaid

Assertive Community Treatment Program

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

The Assertive Community Treatment (ACT) program offers treatment, rehabilitation, and support services using a person-centered, recovery-based approach to individuals who have been diagnosed with severe and persistent mental illness. Individuals receive ACT services including assertive outreach, mental health treatment, health, vocational, integrated dual disorder treatment, family education, wellness skills, community linkages, and peer support from a mobile, multidisciplinary team in community settings. Prior OIG work has shown vulnerabilities in States mental health programs

and their rate-setting methodologies, resulting in Medicaid payments that do not comply with Federal and State requirements. OIG will determine whether (1) Medicaid payments for ACT services complied with Federal and State requirements, and (2) the payment rate for ACT services met the Federal requirement that payment for services be consistent with efficiency, economy, and quality of care.

Work Plan #: A-02-17-01020 (January 2020); A-02-17-01008 (October 2018); A-02-17-01009; W-00-17-31521
Government Program: Medicaid

Medicaid Targeted Case Management

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

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

Work Plan #: A-07-17-03219 (March 2019); A-07-17-03219 (March 2019); A-07-16-03215 (April 2018); W-00-17-31082
Government Program: Medicaid

Medicare Part B Payments for Psychotherapy Services

Expected Issue Date: 2020
Announced/Revised: August 2017

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

Work Plan #: W-00-17-35801; A-09-17-xxxxx
Government Program: Medicare Parts A & B

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Provider

Inpatient Psychiatric Facility Outlier Payments

Expected Issue Date: 2020
Announced/Revised: November 2016

Inpatient Psychiatric Facilities, either freestanding hospitals or specialized hospital-based units, provide active psychiatric treatment to meet the urgent needs of those experiencing an acute mental health crisis, which may involve mental illnesses or alcohol- or drug-related problems. From FY 2014 to FY 2015, the number of claims with outlier payments increased by 28 percent, and total Medicare payments for stays that resulted in outlier payments increased from $450.2 million to $534.6 million (19 percent). OIG will determine whether Inpatient Psychiatric Facilities nationwide complied with Medicare documentation, coverage, and coding requirements for stays that resulted in outlier payments.

Work Plan #: W-00-16-35778
Government Program: Medicare Parts A & B

Medicare Payments for Transitional Care Management

Expected Issue Date: 2020
Announced/Revised: November 2016

Transitional Care Management (TCM) includes services provided to a patient whose medical and/or psychosocial problems require moderate or high-complexity medical decision-making during transitions in care from an inpatient hospital setting (including acute hospital, rehabilitation hospital, long-term acute care hospital), partial hospital, observation status in a hospital, or skilled nursing facility/nursing facility, to the patient's community setting (home, domicile, rest home, or assisted living). Beginning January 1, 2013, Medicare covered TCM services and paid for them under the Medicare Physician Fee Schedule. Medicare-covered services, including chronic care management, end-stage renal disease, and prolonged services without direct patient contact, cannot be billed during the same service period as TCM. OIG will determine whether payments for TCM services were in accordance with Medicare requirements.

Work Plan #: W-00-17-35786
Government Program: Medicare Parts A & B

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Provider

Laboratory

[NEW] Audit of Health Resources and Services Administration's COVID-19 Uninsured Program

Expected Issue Date: 2021
Announced/Revised: October 2020

To address the COVID-19 pandemic, the Families First Coronavirus Response Act (FFCRA) and the Paycheck Protection Program and Health Care Enhancement Act (PPP) together appropriated $2 billion to reimburse providers for costs associated with conducting COVID-19 testing and testing-related items and services for the uninsured. Additionally, a portion of the $175 billion appropriated to the Provider Relief Fund by the Coronavirus Aid, Relief, and Economic Security Act (CARES Act) and PPP will be used for treating uninsured individuals with a confirmed COVID-19 diagnosis. HHS, through the Health Resources and Services Administration (HRSA), launched the COVID-19 Uninsured Program Portal, a single electronic claims processing system for health care providers for submitting claims for reimbursements for diagnostic testing and treating uninsured individuals. OIG will determine whether claims for COVID-19 diagnostic testing and treatment services reimbursed by HHS through HRSA's COVID-19 Uninsured Program complied with Federal requirements.

Work Plan #: W-00-20-30053
Government Program: Department of Health and Human Services (HHS)

Trend Analysis of Medicare Laboratory Billing for Potential Fraud and Abuse With COVID-19 Add-on Testing

Expected Issue Date: 2021
Announced/Revised: June 2020

The coronavirus disease 2019 (COVID-19) pandemic has led to an unprecedented demand for diagnostic laboratory testing to determine whether an individual has the virus. Beyond the COVID-19 tests, laboratories can also perform add-on tests, for example, to confirm or rule out diagnosis other than COVID-19. However, OIG has program integrity concerns related to add-on tests in conjunction with COVID-19 testing, particularly related to potentially fraudulent billing for associated respiratory pathogen panel (RPP) tests, allergy tests, or genetic tests. The Centers for Medicare & Medicaid Services has relaxed rules related to COVID-19 testing and other associated diagnostic laboratory testing to no longer require an order from the treating physician or nonphysician practitioner (NPP) during the COVID-19 public health emergency. Relaxation of the physician ordering/NPP rules could allow unscrupulous actors more leeway for fraudulent billing of unnecessary add-on testing. This study will examine Medicare claims data for laboratory testing to identify trends in the use of RPP, allergy, and genetic testing and identify patterns of billing by laboratories that may indicate fraud and abuse.

Work Plan #: OEI-09-20-00510
Government Program: Medicare Parts A & B

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- Medical Equipment & Supplies
- Physical and Other Therapies
- Accountable Care Organizations
- Behavioral Health
- Laboratory
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- Other Providers and Suppliers

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

Expected Issue Date: 2021
Announced/Revised: June 2020

Medicare is the largest payer of clinical laboratory services in the Nation. Medicare Part B covers most lab tests and pays 100 percent of allowable charges. The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to set Medicare payment rates for lab tests using private payer rates collected from labs. On January 1, 2018, CMS began paying for lab tests under the new system mandated by PAMA. PAMA requires OIG to release an annual analysis of the top 25 laboratory tests by expenditures under Title XVIII of the Social Security Act. In addition, PAMA mandates that OIG conduct analyses it determines appropriate with respect to the implementation and effect of the new payment system. In accordance with PAMA, OIG will publicly release an analysis of the top 25 laboratory tests by expenditures for 2019 and analyze the payments made under the new payment system in 2019, the second year of payments made under the new system for setting payment rates.

Work Plan #: OEI-09-20-00450
Government Program: Medicare Parts A & B

Medicare Part B Payments for Laboratory Services

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

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

Work Plan #: A-06-17-04002 (December 2019); A-04-18-08063 (November 2019);A-06-16-02002 (October 2018); A-09-16-02034 (February 2018); W-00-17-35726; W-00-20-35726
Government Program: Medicare Parts A & B

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Review of Medicare Part B Urine Drug Testing Services

Expected Issue Date: 2020
Announced/Revised: October 2019

Medicare covers treatment services for substance use disorders (SUDs), such as inpatient and outpatient services, when they are reasonable and necessary. SUDs occur when the recurrent use of alcohol or other drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. Medicare also covers clinical laboratory services, including urine drug testing (UDT), under Part B. Physicians use UDT to detect th54e presence or absence of drugs or to identify specific drugs in urine samples. A patient in active treatment for a SUD or being monitored during different phases of recovery from a SUD may undergo medical management for a variety of medical conditions. UDT results influence treatment and level-of-care decisions for individuals with SUDs. The 2018 Medicare fee-for-service improper payment data showed that laboratory testing, including UDT, had an improper payment rate of almost 30 percent, and that the overpayment rate for definitive drug testing for 22 or more drug classes was 71.7 percent. OIG will review UDT services for Medicare beneficiaries with SUD-related diagnoses to determine whether those services were allowable in accordance with Medicare requirements.

Work Plan #: W-00-20-35829
Government Program: Medicare Parts A & B

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Provider

Prescriber

Assessing Trends Related to the Use of Psychotropic Drugs in Nursing Homes

Expected Issue Date: 2021
Announced/Revised: July 2020

Previous OIG work found that elderly nursing home residents who were prescribed antipsychotic drugs—a type of psychotropic drug—were at risk for harm. CMS concurred with some OIG's recommendations and developed new initiatives. However, policymakers continue to raise concerns about whether CMS has made sufficient progress in reducing the use of antipsychotic drugs to care for the elderly. OIG will report the changes over time for the following: (1) the use of psychotropic drugs for elderly nursing home residents; (2) citations and civil monetary penalties assessed to nursing homes regarding psychotropic drugs; and (3) the presence of diagnoses that exclude nursing home residents from CMS's measure of the use of antipsychotic drugs.

Work Plan #: OEI-07-20-00500
Government Program: Medicare Parts A & B

Medicare Payments for Stelara

Expected Issue Date: 2021
Announced/Revised: May 2020

Since 2016, total Medicare Part B payments to physicians for Stelara, an expensive drug used to treat certain autoimmune diseases that is often self-injected by patients in their home-have increased substantially. Such a large increase in payments for a drug that would not typically be covered under Part B raises questions about what is driving the growth, including the possibility of improper billing. In this study, OIG will: (1) determine whether versions of Stelara that are typically self-injected meet the criteria for Medicare Part B coverage; (2) identify factors that may be causing the substantial growth in payments; and (3) determine whether claims for Stelara show evidence of improper billing by physicians.

Work Plan #: OEI-BL-19-00500
Government Program: Medicare Parts A & B

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Provider

Telehealth

[NEW] Medicare Telehealth Services During the COVID-19 Pandemic: Program Integrity Risks

Expected Issue Date: 2021
Announced/Revised: October 2020

In response to the COVID-19 pandemic, CMS implemented a number of waivers and flexibilities that allowed Medicare beneficiaries to access a wider range of telehealth services without having to travel to a health care facility. This review will be based on Medicare Parts B and C data and will identify program integrity risks associated with Medicare telehealth services during the pandemic. OIG will analyze providers' billing patterns for telehealth services. OIG will also describe key characteristics of providers that may pose a program integrity risk to the Medicare program.

Work Plan #: OEI-02-20-00720
Government Program: Medicare Parts A & B

Use of Medicare Telehealth Services During the COVID-19 Pandemic

Expected Issue Date: 2021
Announced/Revised: October 2020

In response to the coronavirus disease 2019 (COVID-19) pandemic, CMS made several changes that allowed Medicare beneficiaries to access a wider range of telehealth services without having to travel to a health care facility. Although these changes are currently temporary, CMS is exploring whether telehealth flexibilities should be extended. These two concurrent reviews will be based on Medicare Parts B and C data and will examine the use of telehealth services in Medicare during the COVID-19 pandemic. The first review will examine the extent to which telehealth services are being used by Medicare beneficiaries, how the use of these services compares to the use of the same services delivered face-to-face, and the different types of providers and beneficiaries using telehealth services. The second review will identify program integrity risks with Medicare telehealth services to ensure their appropriate use and reimbursement during the COVID-19 pandemic.

Work Plan #: OEI-02-20-00520
Government Program: Medicare Parts A & B

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Provider

Medicaid—Telehealth Expansion During COVID-19 Emergency

Expected Issue Date: 2021
Announced/Revised: June 2020

As a result of the coronavirus disease 2019 (COVID-19) pandemic, State Medicaid programs have expanded options for telehealth services. Rapid expansion of telehealth may pose challenges for State agencies and providers, including state oversight of these services. OIG's objective is to determine whether state agencies and providers complied with federal and state requirements for telehealth services under the national emergency declaration, and whether the states gave providers adequate guidance on telehealth requirements.

Work Plan #: W-00-20-31548
Government Program: Medicare Parts A & B

Medicaid Services Delivered Using Telecommunication Systems

Expected Issue Date: 2020
Announced/Revised: November 2017

Medicaid pays for telemedicine, telehealth, and telemonitoring services delivered through a range of interactive video, audio, or data transmission (telecommunications). Medicaid programs are seeing a significant increase in claims for these services and expect this trend to continue. OIG will determine whether selected states' Medicaid payments for services delivered using telecommunication systems were allowable in accord with Medicaid requirements.

Work Plan #: W-00-18-31527; A-06-18-00000
Government Program: Medicaid

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Provider

Other Providers & Suppliers

Infection Control and Emergency Preparedness at Dialysis Centers During the COVID-19 Pandemic

Expected Issue Date: 2021
Announced/Revised: August 2020

The CDC has stated that beneficiaries with serious underlying medical conditions, such as end-stage renal disease (ESRD), are at higher risk for severe illness from COVID-19. Regardless of the current pandemic, dialysis patients are at high risk of infection because of weakened immune systems, coexisting conditions such as diabetes, and treatments requiring frequent use of catheters or insertions of needles to access the bloodstream. ESRD facility conditions for coverage regarding infection control and emergency preparedness are defined in 42 CFR 494 Subpart B. On March 30, 2020, CMS issued a revised memorandum providing guidance for infection control and prevention of COVID-19 in dialysis facilities. OIG will interview corporate officers from the three ESRD service companies covering more than 75 percent of CY 2018 Medicare reimbursements and 71 percent of dialysis clinics. OIG's objective is to determine whether ESRD facilities implemented additional infection control and emergency preparedness procedures in accordance with CMS and CDC guidance to safeguard high risk ESRD beneficiaries during the COVID-19 pandemic.

Work Plan #: W-00-20-35852
Government Program: Medicare Parts A & B

End Stage Renal Disease Networks' Responsibilities During COVID-19

Expected Issue Date: 2021
Announced/Revised: July 2020

The CDC has stated that beneficiaries with serious underlying medical conditions, such as end stage renal Disease (ESRD), are at higher risk for severe illness from COVID-19. As per the CDC, prompt detection, triage, and isolation of potentially infectious patients are essential to prevent unnecessary exposures among patients and health care personnel at dialysis facilities. ESRD treatment facilities are organized into groups called Networks. Network Organizations under CMS contracts develop relationships with dialysis professionals, providers, and patients, and create a collaborative environment to improve patient care. The Network Organizations' contracts include statutory responsibilities and quality improvement activities that could be important in protecting ESRD beneficiaries during the COVID-19 pandemic. In addition to Network Organizations, the ESRD National Coordinating Center (NCC) supports and coordinates activities for the ESRD program on a national level. OIG will interview Network Organizations, NCC, and CMS officials to identify the actions Network Organizations are taking to aid dialysis clinics and patients in response to COVID-19 and keep CMS abreast of quality-of-care issues resulting from COVID-19.

Work Plan #: W-00-20-35851
Government Program: Medicare Parts A & B

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Provider

Advanced Care Planning Services: Compliance with Medicare Requirements

Expected Issue Date: 2021
Announced/Revised: June 2020

In 2016, Medicare began paying for Advanced Care Planning (ACP), which is a face-to-face service through which a Medicare physician (or other qualified health care professional) and a patient discuss the patient's wishes for health care if he or she becomes unable to make decisions about care. It allows Medicare beneficiaries to make important decisions, giving them control over the type of care they receive and when they receive it. Previous reviews have shown improper payments due to a lack of clinical documentation to support face-to-face services, clinical documentation of the time spent discussing ACP, or both. OIG plans to perform a nationwide audit to determine whether Medicare providers for ACP services complied with Federal regulations.

Work Plan #: W-00-20-35848
Government Program: Medicare Parts A & B

Access to Medication-Assisted Treatment at Health Centers

Expected Issue Date: 2021
Announced/Revised: May 2020

Medication-assisted treatment (MAT) is a significant component of the treatment protocols for opioid use disorder and plays a large role in combating the opioid epidemic in the United States. Congress has taken sustained action to support MAT services through broadened prescribing authorities, increased federal funding, and enhanced insurance protections. However, a treatment gap continues to exist where less than one percent of the people in the United States who need treatment for substance use disorder receive it. OIG will examine access to MAT through health centers funded by the Health Resources and Services Administration (HRSA). Health centers are key entities to expand access to MAT because they provide both primary care and behavioral healthcare services and accept patients regardless of their ability to pay. Additionally, in recent years, HRSA has awarded grant funding specifically to expand access to substance use disorder treatment at health center sites. OIG will examine how many health centers provide MAT services, what types of services they provide (e.g., specific medications, behavioral health services such as counseling), how many of their providers are waivered to prescribe MAT drugs, and how many patients they are treating with MAT. OIG will also examine the factors that may either facilitate or hinder the provision of MAT in health centers.

Work Plan #: OEI-BL-19-00320
Government Program: Health Resources and Services Administration

Medicare Part B Payments to Physicians for Co-Surgery Procedures

Expected Issue Date: 2021
Announced/Revised: March 2020

Under Medicare Part B, when the individual skills of two surgeons are necessary to perform a specific surgical procedure or distinct parts of a surgical procedure (or procedures) simultaneously on the same patient during the same operative session (co-surgery), each surgeon should report the specific procedure(s) by billing the same procedure code(s) with a modifier “62.” By appending modifier “62” to the procedure code(s), the fee schedule amount applicable to the payment for

each co-surgeon is 62.5 percent of the global surgery fee schedule amount. OIG plans to audit a sample of claim line items specifically where different physicians billed for the same co-surgery procedure code, for the same beneficiary, on the same date of service. OIG's objective is to determine whether Medicare Part B payments to physicians for co-surgery procedures were properly made.

Work Plan #: W-00-20-35844
Government Program: Medicare Parts A & B

Early Discharges from Inpatient Rehabilitation Facilities to Home Health Services

Expected Issue Date: 2021
Announced/Revised: January 2020

Under the inpatient rehabilitation facility (IRF) prospective payment system (PPS), the Centers for Medicare & Medicaid Services (CMS) established an IRF transfer payment policy based on a per diem amount for each case-mix group (CMG) for which the discharge occurred before the average length of stay for the respective CMG. The IRF transfer payment policy applies to early IRF transfers to another IRF, an inpatient hospital, a nursing home that accepts payments under Medicare or Medicaid, or a long-term-care facility. CMS excluded IRF discharges to home health services from this policy because the home health agency PPS had just been developed and claims data were not available for CMS to analyze. CMS was concerned, however, about IRF incentives to discharge patients prematurely under the IRF PPS to home health services. OIG's objective is to determine how an IRF transfer payment policy for early discharges to home health services would financially affect Medicare Part A and IRFs.

Work Plan #: W-00-20-35831
Government Program: Medicare Parts A & B

Medicare Payments for Chronic Care Management

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions (Alzheimer's disease, arthritis, cancer, diabetes, etc.) that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. These significant chronic conditions are expected to last at least 12 months or until the death of the patient. CCM cannot be billed during the same service period as transitional care management, home health care supervision/hospice care, or certain end-stage renal disease services. Beginning January 1, 2015, Medicare paid separately for CCM under the Medicare Physician Fee Schedule and under the American Medical Association Current Procedural Terminology. OIG will determine whether payments for CCM services were in accordance with Medicare requirements.

Work Plan #: A-07-17-05101 (November 2019); W-00-17-35785
Government Program: Medicare Parts A & B

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Provider

Review of Medicare Facet Joint Procedures

Expected Issue Date: 2020
Announced/Revised: August 2019

Facet joint injections are an interventional technique used to diagnose or treat back pain. Several previous reviews found significant billing errors in this area, including a prior OIG review. OIG will review whether payments made by Medicare for facet joint procedures billed by physicians complied with Federal requirements.

Work Plan #: W-00-19-35825
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: June 2019

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

Work Plan #: W-00-19-30100
Government Program: Medicare Parts A & B

Sleep Disorder Clinics - High Use of Sleep-Testing Procedures

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

An OIG analysis of CY 2010 Medicare payments for Current Procedural Terminology [1] codes 95810 and 95811, which totaled approximately $415 million, showed high utilization associated with these sleep-testing procedures. To the extent that repeated diagnostic testing is performed on the same beneficiary and the prior test results are still pertinent, repeated tests may not be reasonable and necessary. OIG will examine Medicare payments to physicians, hospital outpatient departments, and independent diagnostic testing facilities for sleep-testing procedures to assess payment appropriateness and whether they were in accordance with other Medicare requirements.

Work Plan #: A-04-17-07069 (June 2019); W-00-17-35521; various reviews
Government Program: Medicare Parts A & B

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Provider

Review of Monthly ESRD-Related Visits Billed by Physicians or Other Qualified Healthcare Professionals

Expected Issue Date: 2020
Announced/Revised: April 2019

Most physicians and other practitioners who manage the care of patients who receive outpatient dialysis services at end-stage renal disease (ESRD) facilities are paid a monthly capitation payment (MCP) for ESRD-related physician services. The MCP amount is based on the number of visits provided within each month and the age of the ESRD beneficiary. The physician or other practitioner can bill only one of three current procedural terminology (CPT) codes for ESRD-related visits of one per month, two to three per month, or four or more per month. The Comprehensive Error Rate Testing program's special study of the Healthcare Common Procedure Coding System codes for ESRD-related services found that for some codes, approximately one-third of the payments for ESRD-related services were improper payments due to insufficient documentation, incorrect coding, or no documentation submitted (CMS, Medicare Quarterly Provider Compliance Newsletter Guidance to Address Billing Errors, volume 5, issue 3, April 2015). OIG will review whether physicians or other qualified healthcare professionals billed monthly ESRD-related visits in accordance with Federal requirements.

Work Plan #: W-00-19-35822
Government Program: Medicare Parts A & B

Access Increases in Mental Health and Substance Abuse Services Funding for Health Centers

Expected Issue Date: 2020
Announced/Revised: April 2019

As part of HHS's efforts to fight the national opioid epidemic, the Health Resources and Services Administration (HRSA) awarded $200 million in Access Increases in Mental Health and Substance Abuse Services (AIMS) supplemental funding to 1,178 health centers nation-wide. Health centers use AIMS funding to expand access to critical mental health services and substance abuse services focusing on the treatment, prevention, and awareness of opioid abuse. The AIMS funding was awarded to health centers in September 2017 and covers 12-month budget periods from January 2018 through June 2018. AIMS funding can be used to increase mental health and substance abuse services personnel, leverage health information technology, and provide additional training. OIG will determine whether health centers used their AIMS funding in accordance with Federal requirements and grant terms.

Work Plan #: W-00-19-59442
Government Program: Health Resources and Services Administration

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Provider

Medicare Part B Payments for Podiatry and Ancillary Services

Expected Issue Date: 2020
Announced/Revised: February 2019

Medicare Part B covers podiatry services for medically necessary treatment of foot injuries, diseases, or other medical conditions affecting the foot, ankle, or lower leg. Part B generally does not cover routine foot-care services such as the cutting or removal of corns and calluses or trimming, cutting, clipping, or debridement (i.e., reduction of both nail thickness and length) of toenails. Part B may cover these services, however, if they are performed: (1) as a necessary and integral part of otherwise covered services; (2) for the treatment of warts on the foot; (3) in the presence of a systemic condition or conditions; or (4) for the treatment of infected toenails. Medicare generally does not cover evaluation and management (E&M) services when they are provided on the same day as another podiatry service (e.g., nail debridement performed as a covered service). However, an E&M service may be covered if it is a significant separately identifiable service. In addition, podiatrists may order, refer, or prescribe medically necessary ancillary services such as x-rays, laboratory tests, physical therapy, durable medical equipment, or prescription drugs. Prior OIG work identified inappropriate payments for podiatry and ancillary services. OIG will review Part B payments to determine whether podiatry and ancillary services were medically necessary and supported in accordance with Medicare requirements.
Work Plan #: W-00-19-35818
Government Program: Medicare Parts A & B

Medicare Part B Payments for Ambulance Services Subject to Part A Skilled Nursing Facility Consolidated Billing Requirements

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Medicare Part A prospective payments to skilled nursing facilities (SNFs) include most of the services that outside suppliers provide to SNF residents. Pursuant to 1862(a)(18) and 1842(b)(6)(E) of the Social Security Act, outside suppliers, including ambulance suppliers, must bill and receive payment from the SNF, not Medicare, for services provided to beneficiaries in SNF stays covered under Medicare Part A. Prior Office of Inspector General reports have identified high error rates and significant overpayments for services subject to SNF consolidated billing. OIG will determine whether ambulance services paid by Medicare Part B were subject to Part A SNF consolidated billing requirements. OIG will also assess the effectiveness of edits in CMS's Common Working File to prevent and detect Part B overpayments for ambulance transportation subject to consolidated billing.

Work Plan #: A-01-17-00506 (February 2019); W-00-17-35794
Government Program: Medicare Parts A & B

Ambulance Services - Supplier Compliance with Payment Requirements

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

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

emergency transports. OIG will determine whether Medicare payments for ambulance services were made in accordance with Medicare requirements.

Work Plan #: A-02-16-01021 (December 2018); A-09-17-03018 (July 2018); W-00-17-35574
Government Program: Medicare Parts A & B

Dental Services for Children - Inappropriate Billing

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Dental services are required for most Medicaid-eligible individuals under age 21 as a component of the Early and Periodic Screening, Diagnostic, and Treatment services benefit (SSA §§ 1905(a)(4)(B) and 1905(r)). Federal regulations define dental services as diagnostic, preventative, or corrective procedures provided by or under the supervision of a dentist (42 CFR § 440.100). Services include the treatment of teeth and the associated structure of the oral cavity and disease, injury, or impairment that may affect the oral cavity or general health of the recipient. Previous OIG work indicated that some dental providers may be inappropriately billing for services. OIG will review Medicaid payments by States for dental services to determine whether States have properly claimed Federal reimbursement.

Work Plan #: A-02-16-01020 (November 2018); W-00-17-31135
Government Program: Medicaid

Physicians Billing for Critical Care Evaluation and Management Services

Expected Issue Date: 2020
Announced/Revised: August 2018

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

Work Plan #: W-00-18-35816
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: June 2018

Medicare Part B covers outpatient dialysis services for beneficiaries diagnosed with end-stage renal disease (ESRD). Prior OIG work identified inappropriate Medicare payments for ESRD services. Specifically, OIG identified unallowable Medicare payments for treatments not furnished or documented, services for which there was insufficient documentation

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Laboratory
Prescriber
Telehealth
Other Providers and Suppliers

to support medical necessity, and services that were not ordered by a physician or ordered by a physician that was not treating the patient. OIG will review claims for Medicare Part B dialysis services provided to beneficiaries with ESRD to determine whether such services complied with Medicare requirements.

Work Plan #: W-00-18-35811
Government Program: Medicare Parts A & B

Transportation Services - Compliance with Federal and State Requirements

Expected Issue Date: 2020 PARTIALLY COMPLETED WORK PLAN

Federal regulations require States to ensure necessary transportation for Medicaid beneficiaries to and from providers (42 CFR § 431.53). Each State may have different Medicaid coverage criteria, reimbursement rates, rules governing covered services, and beneficiary eligibility for services. OIG will determine the appropriateness of Medicaid payments by States to providers for transportation services.

Work Plan #: A-05-16-00021 (June 2018); A-07-16-03209 (March 2017); W-00-16-31121
Government Program: Medicaid

Medicare Part B Outpatient Cardiac and Pulmonary Rehabilitation Services

Expected Issue Date: 2020
Announced/Revised: May 2018

Medicare Part B covers outpatient cardiac and pulmonary rehabilitation services. For these services to be covered, however, they must be medically necessary and comply with certain documentation requirements. Previous OIG work identified outpatient cardiac and pulmonary rehabilitation service claims that did not comply with Federal requirements. OIG will assess whether Medicare payments for outpatient cardiac and pulmonary rehabilitation services were allowable in accordance with Medicare requirements. OIG will also determine whether potential risks in outpatient cardiac and pulmonary rehabilitation programs continue to exist.

Work Plan #: W-00-18-35808
Government Program: Medicare Parts A & B

Review of Medicare Payments for Bariatric Surgeries

Expected Issue Date: 2020
Announced/Revised: October 2017

Bariatric surgery is performed to treat comorbid conditions associated with morbid obesity. (A comorbid condition exists simultaneously with another medical condition.) Medicare Parts A and B cover certain bariatric procedures if the beneficiary has: (1) a body mass index of 35 or higher; (2) at least one comorbidity related to obesity; and (3) been previously unsuccessful with medical treatment for obesity. The Comprehensive Error Rate Testing program's special study of certain Healthcare Common Procedure Coding System codes for bariatric surgical procedures found that approximately 98 percent of improper payments lacked sufficient documentation to support the procedures (CMS, Medicare Quarterly Provider Compliance Newsletter, "Guidance to Address Billing Errors," volume 4, issue 4, July 2014).

OIG will review supporting documentation to determine whether the bariatric services performed met the conditions for coverage and were supported in accordance with Federal requirements.

Work Plan #: W-00-17-35226
Government Program: Medicare Parts A & B

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

Expected Issue Date: 2020
Announced/Revised: November 2016

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

Work Plan #: W-00-17-35748
Government Program: Medicare Parts A & B

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Provider