Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Provider-Focused Audits Summary

AUGUST 2019 - AUGUST 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 focused insights into the over 300 audits, performed by HHS OIG, over the last 12 months, SunHawk Consulting, LLC, has gathered, organized, and summarized this audit activity for the Payer and Provider Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The findings and recommendations provided herein are extracted from the specific audits included in this report and referenced by their respective report numbers at the end of each abstract. SunHawk's report summarizes completed audits and evaluations over the last 12 months and sorts relevant audits into Provider and Payer categories. The electronic version of this report includes hyperlinks to the original audits. SunHawk's individual summaries of OIG's completed audits do not include the Auditee's comments which are typically included as an Appendix to the relevant audit report.

After your review, feel free to provide your feedback. If additional information would make this report more valuable to you, please reach out and give us your thoughts. Should you find you would like to proactively conduct a review of activity within your organization to avoid future adverse findings, SunHawk's team of experts are always available to offer their assistance. Visit us at SunHawkConsulting.com and connect with us on LinkedIn for updates on our Healthcare Audit and Enforcement Risk Analysis. SunHawk looks forward to working with you and your organization.

[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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[NEW] Medicare Contractors Were Not Consistent in How They Reviewed Extrapolated Overpayments in the Provider Appeals Process

When an overpayment is identified in Medicare Part A or Part B, providers have the right to contest the overpayment amount using the Medicare administrative appeals process. If a statistical estimate of an overpayment (an extrapolated overpayment) is overturned during the administrative appeals process, then the provider is liable for the overpayment identified in the sample but not the extrapolated amount. Given the large difference between overpayment amounts in the sample and extrapolated amounts, it is critical that the process for reviewing extrapolations during an appeal is fair and reasonably consistent. In the first and second levels of the appeals process, such extrapolated overpayments are reviewed by Medicare administrative contractors (MACs) and qualified independent contractors (QICs), respectively. OIG's objective was to determine whether the Centers for Medicare & Medicaid Services (CMS) ensured that MACs and QICs reviewed appealed extrapolated overpayments consistently and in a manner that conforms with existing CMS requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that, although MACs and QICs generally reviewed appealed extrapolated overpayments in a manner that conforms with existing CMS requirements, CMS did not always provide sufficient guidance and oversight to ensure that these reviews were performed in a consistent manner. The most significant inconsistency OIG identified involved the use of a type of simulation testing that was performed only by a subset of contractors. The test was associated with at least $42 million in extrapolated overpayments that were overturned in fiscal years 2017 and 2018. If CMS did not intend that the contractors use this procedure, these extrapolations should not have been overturned. Conversely, if CMS intended that contractors use this procedure, it is possible that other extrapolations should have been overturned but were not. In addition, CMS's ability to provide oversight over the extrapolation review process was limited because of data reliability issues in the Medicare Appeals System (MAS). Of the 39 appeals cases OIG reviewed that were listed in the MAS as involving extrapolation, 19 cases did not actually involve statistical sampling. Improving the accuracy of the information in the MAS would potentially assist CMS with ensuring that extrapolated overpayments are reviewed by the MACs and QICs in a consistent manner.

OIG recommended that CMS: (1) provide additional guidance to contractors to ensure reasonable consistency in procedures used to review extrapolated overpayments during the first two levels of the Medicare Parts A and B appeals process; (2) take steps to identify and resolve discrepancies in the procedures contractors use to review extrapolations during the appeals process; (3) provide guidance regarding the organization of extrapolation related files that must be submitted in response to a provider appeal; (4) improve system controls to reduce the risk of contractors incorrectly marking the extrapolation flag field in the MAS; and (5) update the information in the MAS to accurately reflect extrapolation amounts challenged as part of an appeal, whether the extrapolation was reviewed by a contractor, and the outcome of any extrapolation review.

Work Plan #: A-05-18-00024 (August 2020)
Government Program: Medicare Parts A & B

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[NEW] Texas Relied on Impermissible Provider-Related Donations To Fund the State Share of the Medicaid Delivery System Reform Incentive Payment Program

Delivery System Reform Incentive Payment (DSRIP) Program payments are incentive payments made to hospitals and other providers that develop programs or strategies to enhance access to health care, increase the quality and cost-effectiveness of care, and increase the health of patients and families served. These incentive payments have significantly increased funding to providers for their efforts related to the quality of services. Texas made DSRIP Program payments totaling almost $10 billion for five years. OIG's objective was to determine whether Texas used permissible funds as the state share of DSRIP Program payments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that $146.6 million in funds that Texas used as the state share of DSRIP Program payments was funded through impermissible provider-related donations that did not meet Federal requirements. Those funds were derived from impermissible provider-related donations because the providers made donations that benefited the IGT entity, the funds the IGT entity transferred resulted from those donations, and the providers' donations were part of a hold-harmless practice. Texas did not decrease its Medicaid expenditures by the $146.6 million as required under federal requirements. As a result, Texas inappropriately received $83.8 million in federal funds.

OIG recommended that Texas (1) refund the $83.8 million it inappropriately received because it used intergovernmental transfers (IGTs) derived from impermissible provider-related donations as the state share of DSRIP Program payments, (2) provide its IGT entities with guidance about arrangements that may result in impermissible provider-related donations, such as those outlined in the Centers for Medicare & Medicaid Services' (CMS's) clarifying letter, and (3) request that its IGT entities disclose whether similar arrangements exist and provide Texas with action plans on ending the arrangements.

Work Plan #: A-06-17-09002 (August 2020)
Government Program: Medicaid

[NEW] Inadequate Edits and Oversight Caused Medicare To Overpay More Than $267 Million for Hospital Inpatient Claims With Post-Acute-Care Transfers to Home Health Services

Prior OIG audits identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (transfer policy). CMS generally concurred with OIG recommendations, but subsequent analysis that OIG conducted indicated that CMS's system edits were still not properly designed and that hospitals may be using condition codes to bypass CMS's system edits to receive higher reimbursements for inpatients transferred to home health services. OIG's objective was to determine whether Medicare properly paid acute-care hospital inpatient claims subject to the

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transfer policy when hospitals: (1) did not code the claims as a discharge to home with home health services when the beneficiary resumed home health services within three days of discharge, (2) applied condition code 43 indicating that the home health services were not provided within three days of discharge, or (3) applied condition code 42 indicating that the home health services were not related to the inpatient hospital services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Medicare improperly paid most inpatient claims subject to the transfer policy when beneficiaries resumed home health services within three days of discharge, but the hospitals failed to code the inpatient claim as a discharge to home with home health services or when the hospitals applied condition codes 42 (home health not related to inpatient stay) or 43 (home health not within 3 days of discharge). Of the 150 inpatient claims in OIG's sample, Medicare improperly paid 147 with $722,288 in overpayments. Medicare should have paid these inpatient claims using a graduated per diem rate rather than the full payment. Based on OIG's sample results, OIG estimated that Medicare improperly paid $267 million during a two-year period for hospital services that should have been paid a graduated per diem payment.

OIG recommended that CMS direct its Medicare contractors, for the claims that are within the four-year reopening period, to: (1) recover a portion of the $722,288 in overpayments identified in OIG's sample, (2) reprocess the remaining inpatient claims in OIG's sample frame with an incorrect patient discharge status code or condition code 43 to recover a portion of the estimated $225.7 million in overpayments, and (3) analyze the remaining inpatient claims in OIG's frame with condition code 42 and recover a portion of the estimated $40.6 million in potential overpayments. Also, OIG recommended that CMS correct its related system edits, improve its provider education related to the Medicare transfer policy, and use data analytics to identify hospitals disproportionally using condition code 42. Finally, OIG recommended that CMS consider reducing the need for clinical judgment when processing claims under the post-acute-care transfer policy by taking the necessary actions, including seeking legislative authority if necessary, to deem any home health service within three days of discharge to be "related."

Work Plan #: A-04-18-04067 (August 2020)
Government Program: Medicare Parts A & B

Hospitals Overbilled Medicare $1 Billion by Incorrectly Assigning Severe Malnutrition Diagnosis Codes to Inpatient Hospital Claims

Previous OIG audits of severe malnutrition found that hospitals had incorrectly billed Medicare by using severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all. Diagnosis codes E41 and E43 (severe malnutrition diagnosis codes) are each classified as a type of major complication or comorbidity (MCC). Adding MCCs to a Medicare claim can result in a higher Medicare payment. OIG's objective was to determine whether hospitals complied with Medicare billing requirements when assigning severe malnutrition diagnosis codes to inpatient hospital claims.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that hospitals did not correctly bill Medicare for the 173 claims audited. For nine of these claims, the medical record documentation supported a secondary diagnosis code other than a severe malnutrition diagnosis code, but the

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error did not change the DRG or payment. For the remaining 164 claims, hospitals used severe malnutrition diagnosis codes when they should have used codes for other forms of malnutrition or no malnutrition diagnosis code at all, resulting in net overpayments of $914,128. Based on OIG's sample results, OIG estimated that hospitals received overpayments of $1 billion for FYs 2016 and 2017.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) collect the portion of the $914,128 for the incorrectly billed hospital claims that are within the reopening period and, based upon the results of this audit, notify appropriate providers so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule. Additionally, OIG recommended CMS review all claims that were not part of OIG's sample but were within the reopening period.

Work Plan #: A-03-17-00010 (July 2020)
Government Program: Medicare Parts A & B

Medicare Hospital Provider Compliance Audit: The Ohio State Hospital, Texas Health Presbyterian Hospital, and Northwest Medical Center

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, OIG identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals $206 billion, which represents 55 percent of all fee-for-service payments for the year.

SunHawk Summary of OIG Audit Findings and Recommendations

Ohio State Hospital (A-05-18-00042)

OIG found that Ohio State Hospital did not fully comply with Medicare billing requirements for 47 claims, resulting in net overpayments of $335,832 for the audit period. Specifically, 26 inpatient claims had billing errors, resulting in overpayments of $291,998, and 21 outpatient claims had billing errors, resulting in overpayments of $43,834. Based on OIG sample results, OIG estimated that Ohio State Hospital received overpayments of at least $3.7 million for the audit period.

OIG recommended Ohio State Hospital refund to the Medicare contractor $3.7 million in estimated overpayments for incorrectly billed services that are within the four-year claim reopening period; exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Texas Health Presbyterian Hospital *(A-04-18-08068)*

OIG found that Texas Health Presbyterian Hospital did not fully comply with Medicare billing requirements for the 41 claims, resulting in net overpayments of $500,323 for the audit period. The 40 inpatient claims had billing errors, resulting in net overpayments of $500,232 and one outpatient claim had a billing error, resulting in an overpayment of $91. Specifically, Texas Health Presbyterian Hospital incorrectly billed:

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- 27 inpatient rehabilitation claims that either did not meet coverage or documentation requirements,
- Eight inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation
- One outpatient and Five inpatient claims that were incorrectly coded.

Based on OIG's sample results, OIG estimated that Texas Health Presbyterian Hospital received overpayments of at least $10.7 million for the audit period. During OIG's audit, Texas Health Presbyterian Hospital submitted 13 of these claims for reprocessing, and OIG verified those claims as correctly reprocessed. Accordingly, OIG have reduced the recommended refund by $114,415.

OIG recommended Texas Health Presbyterian Hospital refund to the Medicare contractor $10.6 million ($10.7 million less $114,415 that the Hospital has already repaid) in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG's audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Northwest Medical Center *(A-04-18-08064)*

OIG reported that Northwest Medical Center did not fully comply with Medicare billing requirements for the 20 claims, resulting in overpayments of $201,624 for the audit period. 13 inpatient claims had billing errors, resulting in overpayments of $200,495, and 7 outpatient claims had billing errors, resulting in overpayments of $1,129. Specifically, Northwest Medical Center incorrectly billed:

- nine inpatient rehabilitation claims that did not meet coverage requirements,
- two inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation, and
- two inpatient and seven outpatient claims that were incorrectly coded.

Based on OIG's sample results, OIG estimated that Northwest Medical Center received overpayments of at least $1.2 million for the audit period. During OIG's audit, Northwest Medical Center submitted six of these claims for reprocessing, and OIG verified those claims as correctly reprocessed. Accordingly, OIG have reduced the recommended refund by $4,024.

OIG recommended the Hospital refund to the Medicare contractor at least $1.2 million in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Carolinas Hospital (A-04-18-08063)

OIG found that Carolinas Hospital did not fully comply with Medicare billing requirements for the 45 claims, resulting in overpayments of $431,757 for the audit period. 41 inpatient claims had billing errors, resulting in overpayments of $431,431, and four outpatient claims had billing errors, resulting in overpayments of $326. Specifically, the Hospital incorrectly billed: 22 inpatient rehabilitation claims that did not meet coverage requirements, 15 inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation, four inpatient claims and one outpatient claim that were incorrectly coded, and three outpatient claims that were subject to the consolidated billing requirements. Based on OIG sample results, OIG estimated that the Hospital received overpayments of at least $3.4 million for the audit period.

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OIG recommended that Carolinas Hospital refund to the Medicare contractor at least $3.4 million in estimated overpayments for the audit period for claims that it incorrectly billed; exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Work Plan #: A-05-18-00042 (May 2020); A-04-18-08068 (December 2019); A-04-18-08063 (November 2019); A-04-18-08064 (November 2019)
Government Program: Medicare Parts A & B

Selected Inpatient and Outpatient Billing Requirements

This review was part of a series of hospital compliance reviews that focused 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 reviewed Medicare payments to acute care hospitals to determine hospitals' compliance with selected billing requirements and recommended recovery of overpayments. OIG's review focused on those hospitals with claims that may be at risk for overpayments.

SunHawk Summary of OIG Findings and Recommendations

Saint Francis Health Center (A-07-17-05102)

OIG found that Saint Francis Health Center did not fully comply with Medicare billing requirements for 51 claims, resulting in overpayments of $707,118 for calendar years 2015 and 2016. Based on OIG sample results, OIG estimated that the Hospital received overpayments of at least $5.5 million for the audit period.

OIG recommended that Saint Francis Health Center refund to the Medicare contractor $5.5 million of the estimated overpayments for the claims incorrectly billed that are within the Medicare reopening period; for the remaining portion of the estimated $5.5 million overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and strengthen controls to ensure full compliance with Medicare requirements.

Community Hospital (A-05-17-00026)

OIG found that Community Hospital did not fully comply with Medicare billing requirements for 86 claims, all of which were inpatient, resulting in net overpayments of $1,266,758 for calendar years 2015 and 2016. These errors occurred primarily because Community Hospital did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas that contained errors. Based on OIG sample results, OIG estimated that Community Hospital received overpayments of at least $22 million for OIG's audit period.

OIG recommended that Community Hospital refund the Medicare contractor $22 million (of which $1,266,758 was net overpayments identified in OIG sample) in estimated overpayments for the audit period for claims that it incorrectly billed;

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exercise reasonable diligence to identify and return any additional similar overpayments received outside of OIG audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

Work Plan #: A-07-17-05102 (March 2020); A-05-17-00026; (February 2019); A-04-17-08057 (October 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 Programs: Medicare Parts A & B

Outpatient Outlier Payments for Short-Stay Claims

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 determined the extent of potential Medicare savings if hospital outpatient short stays (same day or over one midnight) were ineligible for an outlier payment.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that St. Vincent did not properly bill the 103 of 120 sampled claims which resulted in improper outlier payments during OIG audit period. These 103 claims, which had outliers totaling $581,136, contained 173 billing errors. The billing errors primarily occurred because St. Vincent did not have adequate controls to prevent errors related to overcharged time, charge errors, and coding errors.

OIG recommended that St. Vincent amend the claims with errors to identify and return any improper outlier payments. OIG also recommended that St. Vincent improve procedures and provide education to ensure claims billed to Medicare are accurate.

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

Follow-up Review on Inpatient Claims Subject to the Post-Acute-Care Transfer Policy

Medicare makes the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to a hospital that discharges an inpatient beneficiary "to home." Under the post-acute-care transfer policy, however, for certain qualifying MS-DRGs, Medicare pays a hospital that transfers an inpatient beneficiary to post-acute care a per diem rate for each day of the stay, not to exceed the full MS-DRG payment that would have been made if the inpatient beneficiary had been discharged to home. A prior OIG review identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy. OIG found that hospitals transferred patients to certain post-acute-care settings but improperly claimed the higher reimbursement associated with discharges "to home." Specifically, these hospitals used incorrect

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patient discharge status codes on their claims by indicating that their patients were discharged "to home" rather than transferred to a post-acute-care setting. OIG's review found that CMS common working file (CWF) edits related to transfers to home health care, SNFs, and non-IPPS hospitals were not working properly. As a result, OIG recommended that CMS correct the CWF edits, ensure they are working properly, and recover the identified overpayments in accordance with its policies and procedures. CMS agreed with the recommendations and stated that it will update the CWF edits. This follow-up audit determined whether CMS corrected the CWF edits and ensured they are working properly.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported Medicare improperly paid acute-care hospitals $54.4 million for 18,647 claims subject to the transfer policy. These hospitals improperly billed the claims by using the incorrect patient discharge status codes. Specifically, they coded these claims as discharges to home (16,599 claims) or to certain types of healthcare institutions (2,048 claims), such as facilities that provide custodial care, rather than as transfers to post-acute care. Of these claims, 83 percent were followed by claims for home health services, and 17 percent were followed by claims for services in other post-acute-care settings.

OIG recommended CMS direct the Medicare contractors to (1) recover the $54.4 million in identified overpayments, (2) identify any claims for transfers to post-acute care in which incorrect patient discharge status codes were used and direct the Medicare contractors to recover any overpayments after OIG audit period, and (3) ensure that the Medicare contractors are receiving the post payment edit's automatic notifications of improperly billed claims and are taking action by adjusting the original inpatient claims to initiate recovery of the overpayments.

Work Plan #: A-09-19-03007 (November 2019); W-00-19-35820
Government Program: Medicare Parts A & B

Reconciliations of Outlier Payments

Outliers are additional payments that Medicare provides to hospitals for beneficiaries who incur unusually high costs. The original outlier payments are based on the cost-to-charge ratio from the most recently settled cost report. The actual cost-to-charge ratio for the year in which the service was provided is available only at the time of cost report settlement for that year. Centers for Medicare & Medicaid Services performs outlier reconciliations at the time of cost report settlement. Without timely reconciliations and final settlements, the cost reports remain open and funds may not be properly returned to the Medicare Trust Fund. OIG reviewed Medicare outlier payments to hospitals determining whether Centers for Medicare & Medicaid Services performed necessary reconciliations in a timely manner to enable Medicare contractors to perform final settlement of the hospitals' associated cost reports. OIG determined whether the Medicare contractors referred all hospitals that meet the criteria for outlier reconciliations to Centers for Medicare & Medicaid Services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that from fiscal years 2011 through 2014, CMS paid the 60 hospitals a net of $502 million more in outlier payments than the hospitals would have been paid if their outlier payments had been timely reconciled. (OIG refers to this net amount as excessive outlier payments). Specifically, CMS paid 53 hospitals $541 million more than they would have been paid and 7 hospitals $39 million less than they would have been paid over the four-year period. CMS did not detect or recover these excessive outlier payments because the 236 associated cost reports did not meet the ten-percentage point threshold for reconciliation.

OIG recommended CMS require reconciliation of all hospital cost reports with outlier payments during a cost-reporting period. If the reconciliation requirement had been in effect for the 60 hospitals in OIG audit, CMS would have saved approximately $125 million per year.

Work Plan #: A-05-16-00060 (November 2019); W-00-16-35451; W-00-16-35781
Government Program: Medicare Parts A & B

Health-Care-Acquired Conditions - Prohibition on Federal Reimbursements

As of July 1, 2011, Federal payments to states are prohibited for any amounts expended for providing medical assistance for health-care-acquired conditions. 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. OIG determined 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.

SunHawk Summary of OIG Audit Findings and Recommendations:

Texas (A-06-16-01001)

OIG found that Texas did not ensure that its Managed Care Organizations (MCOs) complied with federal and state requirements prohibiting payments to providers for inpatient hospital services related to treating certain Provider Preventable Conditions (PPCs). For OIG's audit period, OIG identified Medicaid claims totaling $29.4 million that contained PPCs for five MCOs. Of this amount, OIG determined that claims totaling $12.7 million followed federal and state regulations regarding nonpayment of PPCs. However, claims totaling $16.7 million were not in compliance. Texas' internal controls were not adequate to ensure that its MCOs complied with federal and state requirements. Specifically, Texas (1) did not have policies and procedures to determine whether its MCOs complied with Federal and State requirements and provisions of the managed-care contract relating to the nonpayment of PPCs and (2) did not ensure that the MCOs' payment rates were based only on services that were covered in the State plan.

OIG recommended that Texas work with the five MCOs to determine what portion of the $16.7 million is unallowable for Federal Medicaid reimbursement and that portion's impact on current- and future-year capitation payment rates. OIG also made procedural recommendations to Texas that it strengthen its monitoring of all MCOs to ensure compliance with federal and state requirements and its managed-care contracts relating to the nonpayment of PPCs.

Pennsylvania (A-03-16-00205)

OIG found that Pennsylvania did not ensure that its MCOs complied with Federal and State requirements prohibiting Medicaid payments to providers for inpatient hospital services related to treating certain PPCs. PPCs are certain reasonably preventable conditions caused by medical accidents or errors in a health care setting. For OIG's audit period, OIG identified that MCOs paid providers approximately $43.5 million for 576 claims that contained PPCs. Pennsylvania's policies and procedures were not adequate to ensure its MCOs complied with Federal and State requirements. As a result, unallowable payments for services related to treating PPCs might have been included in the calculation of capitation payment rates.

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OIG made several recommendations to Pennsylvania, including (1) work with the MCOs to determine the portion of the $43.5 million that was unallowable for claims containing PPCs and its impact on current- and future-year capitation payment rates, (2) include a clause in its managed-care agreements with the MCOs that would allow Pennsylvania to recoup funds from the MCOs when contract provisions and Federal and State requirements are not met—a measure that, if incorporated, could result in cost savings for Medicaid, and (3) enforce the provisions in its managed-care agreements that allow sanctions or penalties to be imposed for noncompliance with or failure to meet performance and program standards indicated in the contract and subsequent related contracts.

New York (A-02-16-01022)

OIG was unable to determine whether New York complied with Federal and State requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs because New York did not provide sufficient evidence that it properly identified claims containing PPCs or determined whether the payments for the related services should have been reduced. Without such evidence, OIG could not verify whether New York's payments for claims containing PPCs were appropriately reduced.

OIG made a series of recommendations to New York, including that it provides CMS with sufficient documentation to determine whether any portion of the $50.3 million Federal Medicaid reimbursement was unallowable and refund to the Federal Government the unallowable amount. In written comments on OIG draft report, New York generally agreed with OIG recommendations; however, it disagreed with OIG's finding. Although New York asserts that it is appropriately reducing payments in accordance with Federal and State requirements, OIG maintained that, without sufficient evidence to support its assertion, OIG cannot objectively determine whether it complied with requirements prohibiting Medicaid payments for inpatient hospital services related to treating certain PPCs. Therefore, OIG maintained that OIG finding and related recommendations are valid.

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; A-06-16-02003 (December 2018); W-00-16-31452
Government Program: Medicaid

Review of Hospital Wage Data Used to Calculate Medicare Payments

Hospitals report wage data annually to Centers for Medicare & Medicaid Services, which is then used to calculate wage index rates to account for different geographic area labor market costs. Prior OIG wage index work identified hundreds of millions of dollars in incorrectly reported wage data and resulting in policy changes by Centers for Medicare & Medicaid Services regarding how hospitals report deferred compensation costs. OIG reviewed hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Rhode Island Hospital did not always comply with Medicare requirements when reporting its wage data used by CMS for the FFY 2019 hospital wage index calculation. As a result, Rhode Island Hospital overstated its wages and wage-related costs.

OIG recommended that Rhode Island Hospital (1) ensure that all personnel involved in the process are fully trained to comply with Medicare wage data reporting requirements, (2) annually review all software scripts and manual procedures

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to ensure compliance with Medicare wage data reporting requirements, and (3) implement more effective quality controls over the entry of contract labor data into its accounting system.

Work Plan #: A-01-17-00509 (October 2019); A-01-17-00510 (May 2019); A-01-17-00500 (November 2018); W-00-16-35452; W-00-17-35725
Government Program: Medicare Parts A & B

Patient Safety Organizations: Hospital Participation, Value, and Challenges

The Patient Safety Organization (PSO) program established federally recognized PSOs to work with health care providers to improve the safety and quality of patient care. The Patient Safety and Quality Improvement Act of 2005 created the PSO program, and in 2008 the Agency for Healthcare Research and Quality (AHRQ) published the final Patient Safety Rule implementing the Act. OIG has determined the reach and value of the PSO program among hospitals. OIG also assessed AHRQ's oversight of the PSO program and identified challenges the program faces.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported forty-two percent (31 of 74) of PSOs cannot contribute to the Network of Patient Safety Databases (NPSD), because they do not use the Common Formats. Challenges with the Common Formats reflect the limits of using a standardized approach to capturing patient safety data. Finally, AHRQ provides technical assistance that PSOs find helpful, but its guidance falls short of meeting PSOs' needs.

OIG recommended that AHRQ (1) develop and execute a communications strategy to increase nonparticipating hospitals' awareness of the PSO program and the program's value to participants; (2) take steps to encourage PSOs to participate in the NPSD, including accepting data into the NPSD in other formats in addition to the Common Formats; and (3) update guidance for PSOs on processes for listing PSOs.

Work Plan #: OEI: 01-17-00420 (September 2019)
Government Program: Patient Safety Organization (PSO) program

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Provider

Long Term Care

[NEW] New Jersey Did Not Ensure That Incidents of Potential Abuse or Neglect of Medicaid Beneficiaries Residing in Nursing Facilities Were Always Properly Investigated and Reported

This audit report is one of a series of OIG reports that addresses the identification, reporting, and investigation of incidents of potential abuse and neglect of our Nation's most vulnerable populations, including Medicaid beneficiaries in nursing facilities. Nursing facility residents are at increased risk of abuse and neglect when healthcare professionals and caregivers fail to report abuse, or when incidents of potential abuse or neglect are not acted upon in a timely manner. OIG's objective was to determine whether New Jersey ensured that incidents of potential abuse or neglect of Medicaid beneficiaries residing in nursing facilities in New Jersey were properly reported and investigated in accordance with applicable federal and state requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that 10 claims in OIG's sample were the result of potential abuse or neglect that should have been reported to the state. However, five of the ten claims were not properly investigated and reported to the state. For 14 claims, nursing facilities did not provide documentation, or their records did not contain sufficient documentation for state officials to determine whether the incident should have been investigated and reported. These deficiencies occurred because nursing facility staff did not follow requirements for investigating and reporting potential incidents of abuse or neglect. In addition, New Jersey did not have adequate survey procedures for ensuring that nursing facilities documented all such incidents.

Based on OIG's sample results, OIG estimated that 311 Medicaid hospital claims with selected diagnosis codes resulted from incidents of potential abuse or neglect at a nursing facility in New Jersey during CY 2016. Of this amount, OIG estimated that 220 claims were the result of potential abuse or neglect that the nursing facilities did not investigate and report to the state. In addition, OIG estimated that, for 616 claims, the associated beneficiary's nursing facility did not have records to sufficiently document the circumstances of the beneficiary's injuries or condition that led to the hospital transfer so that state officials could determine whether the incident was the result of potential abuse or neglect.

OIG recommended that New Jersey: (1) reinforce guidance to nursing facilities for ensuring potential incidents of abuse or neglect are reported in accordance with federal and state requirements, and (2) develop additional procedures for its survey site visits, including reviewing nursing facilities' records related to hospital transfers for certain beneficiary injuries or conditions that could be the result of potential abuse or neglect.

Work Plan #: A-02-18-01006 (August 2020)
Government Program: Medicaid

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Provider

[NEW] Some Nursing Homes' Reported Staffing Levels in 2018 Raise Concerns and Consumer Transparency Could Be Increased

Nurse staffing is a key contributor to the quality of care provided in nursing homes. This review, initiated before the COVID-19 pandemic emerged, focuses on staffing data from 2018. However, the 2020 pandemic reinforces the importance of adequate staffing for nursing homes, as inadequate staffing can make it more difficult for nursing homes to respond to infectious disease outbreaks like COVID-19. Consumers need meaningful information about nurse staffing at nursing homes to make informed care decisions. CMS created the Payroll-Based Journal (PBJ)-a system containing self-reported provider data-to collect nursing homes' daily staffing hours. CMS uses the PBJ data to calculate Staffing Star Ratings reported on the public Nursing Home Compare website. CMS requires a minimum number of daily hours for different types of nurses (nursing homes must have a registered nurse (RN) on staff at least eight hours each day and licensed nurses on staff around the clock). However, CMS does not use PBJ data to enforce these daily federal staffing requirements, nor does it regularly publish day-to-day nurse staffing on Nursing Home Compare.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that seven percent (943) of nursing homes reported 30 or more days in 2018 on which staffing was below at least one required staffing level. Additionally, another seven percent of nursing homes (900) reported between 16 and 29 days with staffing below required levels in 2018. This raise concerns that some nursing homes may not have fully met their residents' needs in 2018. CMS implemented a policy in 2018 to downgrade nursing homes' Staffing Star Ratings to one Star for having at least seven total days within a quarter with no reported RN time. Following CMS's announcement of this policy, 27 percent fewer nursing homes reported days with no RN time. At the same time, seven percent more nursing homes reported days with some RN time, although less than the required eight hours per day. These trends suggest overall improvements in staffing levels. Finally, OIG found that daily staffing levels reported by individual nursing homes often did not match their Staffing Star Rating published on Nursing Home Compare. While some nursing homes' reported staffing levels varied considerably from day to day, other nursing homes' daily staffing levels were more consistent.

OIG recommended that CMS: (1) enhance efforts to ensure nursing homes meet daily staffing requirements, and (2) explore ways to provide consumers with additional information on nursing homes' daily staffing levels and variability.

Work Plan #: OEI-04-18-00450 (August 2020)
Government Program: Medicare Parts A & B

California, Missouri, Texas and Florida Should Improve their Oversight of Selected Nursing Homes' Compliance with Federal Requirements for Life Safety and Emergency Preparedness

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term-care facilities (commonly known as nursing homes). The updates included requirements that nursing homes have expanded sprinkler systems and smoke detector coverage; an emergency plan that is reviewed, trained on, tested, and updated at least annually; and provisions for sheltering in place and for evacuation. OIG's objective was to determine whether

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California, Missouri, Texas, and Florida ensured that selected nursing homes in the state that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness.

SunHawk Summary of OIG Audit Findings and Recommendations

Florida (A-04-18-08065)

OIG reported that all 20 nursing homes that OIG visited had deficiencies in areas related to life safety or emergency preparedness. Specifically, 19 nursing homes had 100 areas of noncompliance with life safety requirements related to building exits and smoke barriers, fire detection and suppression systems, hazardous storage areas, smoking policies and fire drills, and electrical equipment. Furthermore, 16 nursing homes had 87 areas of noncompliance with emergency preparedness requirements related to written emergency plans, emergency supplies and power, plans for sheltering in place and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training. The instances of noncompliance occurred because of several contributing factors, specifically inadequate management oversight and staff turnover at the nursing homes. In addition, OIG reported Florida did not have a standard life safety training program for all nursing home staff and generally performed life safety surveys no more frequently than once every 12 to 15 months, even at these higher risk nursing homes.

OIG recommended Florida (1) follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) work with CMS on developing life safety training for nursing home staff, and (3) conduct more frequent surveys at nursing homes with a history of multiple high-risk deficiencies and follow up to ensure that corrective actions have been taken.

Missouri (A-07-18-03230)

During OIG's onsite inspections, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 20 nursing homes. OIG found 178 areas of noncompliance with life safety requirements related to building exits, fire detection and suppression systems, hazardous storage, smoking policies, and electrical equipment maintenance, among others. OIG also found 149 areas of noncompliance with emergency preparedness requirements related to written plans, emergency power, emergency communications, and training, among others. As a result, residents at the 20 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified areas of noncompliance occurred because Missouri did not ensure that issues related to inadequate management oversight and high staff turnover at nursing homes were identified and corrected. In addition, Missouri did not adequately follow up on deficiencies previously cited.

OIG recommended Missouri follow up with the 20 nursing homes to ensure that corrective actions have been taken regarding the identified deficiencies. OIG made other procedural recommendations to Missouri regarding the development of standardized life safety training for nursing home staff, the conducting of more frequent surveys and follow-up at nursing homes with a history of multiple high-risk deficiencies, and updates of facility-specific plans.

Texas (A-06-19-08001)

OIG reported that during OIG's onsite inspections, OIG identified deficiencies in areas related to life safety or emergency preparedness at 18 nursing homes. Specifically, OIG found 235 deficiencies with life safety requirements related to building exits and smoke partitions, fire detection and suppression systems, hazardous storage areas, fire drills and smoking policies, and electrical equipment and elevator inspection and testing. OIG found 55 deficiencies with emergency

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preparedness requirements related to written emergency plans, emergency supplies and power, emergency communications plans, and emergency plan training. As a result, residents at the 18 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified deficiencies occurred because management oversight at nursing homes was inadequate, and nursing homes had high maintenance and administrative staff turnover. In addition, maintenance personnel at some of the nursing homes indicated that building maintenance is challenging because of the advanced age of some buildings.

OIG recommended Texas follow up with the 18 nursing homes to verify that corrective actions have been taken regarding the life safety and emergency preparedness deficiencies identified in this report.

California (A-09-18-02009)

During OIG's site visits, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 19 nursing homes that OIG reviewed. Specifically, OIG found 137 instances of noncompliance with life safety requirements related to building exits, smoke barriers, and smoke partitions; fire detection and suppression systems; hazardous storage areas; smoking policies and fire drills; and electrical equipment testing and maintenance. OIG also found 188 instances of noncompliance with emergency preparedness requirements related to written emergency plans; emergency power; plans for evacuation, sheltering in place, and tracking residents and staff during and after an emergency; emergency communications plans; and emergency plan training and testing. As a result, nursing home residents at the 19 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified deficiencies occurred because nursing homes lacked adequate management oversight and had high staff turnover. In addition, California did not adequately follow up on deficiencies previously cited, ensure that surveyors were consistently enforcing CMS requirements, or have a standard life safety training program for all nursing home staff (not currently required by CMS).

OIG recommended California (1) follow up with the 19 nursing homes to ensure that corrective actions have been taken regarding the deficiencies OIG identified, (2) conduct more frequent site surveys at nursing homes to follow up on deficiencies, (3) ensure that all surveyors consistently enforce CMS requirements, and (4) work with CMS to develop life safety training for nursing home staff.

Work Plan #: A-04-18-08065 (March 2020); A-07-18-03230 (March 2020); A-06-19-08001 (February 2020); A-09-18-02009 (November 2019)
Government Program: Medicare Parts A & B

Life Safety and Emergency Preparedness Deficiencies Found at 18 of 20 Texas Nursing Homes

In 2016, the Centers for Medicare & Medicaid Services (CMS) updated its life safety and emergency preparedness regulations to improve protections for all Medicare and Medicaid beneficiaries, including those residing in long-term-care facilities (commonly referred to as nursing homes). Updates included requirements that nursing homes have expanded sprinkler systems and smoke detector coverage; an emergency preparedness plan that is reviewed, trained on, tested, and updated at least annually; and provisions for sheltering in place and evacuation.

OIG's objective was to determine whether selected nursing homes in Texas that received Medicare funds, Medicaid funds, or both, complied with Federal requirements for life safety and emergency preparedness.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that during OIG onsite inspections, OIG identified deficiencies in areas related to life safety or emergency preparedness at 18 of the 20 nursing homes that OIG audited. Specifically, OIG found 235 deficiencies with life safety requirements related to building exits and smoke partitions, fire detection and suppression systems, hazardous storage areas, fire drills and smoking policies, and electrical equipment and elevator inspection and testing. OIG found 55 deficiencies with emergency preparedness requirements related to written emergency plans, emergency supplies and power, emergency communications plans, and emergency plan training. As a result, residents at the 18 nursing homes were at increased risk of injury or death during a fire or other emergency. The identified deficiencies occurred because management oversight at nursing homes was inadequate, and nursing homes had high maintenance and administrative staff turnover. In addition, maintenance personnel at some of the nursing homes indicated that building maintenance is challenging because of the advanced age of some buildings.

OIG recommended Texas follow up with the 18 nursing homes to verify that corrective actions have been taken regarding the life safety and emergency preparedness deficiencies identified in this report.

Work Plan #: A-06-19-08001 (February 2020)
Government Program: Medicare Parts A & B

Highlands of Little Rock West Markham Holdings, LLC: Audit of Documentation of Therapy Resource Utilization Groups

Skilled Nursing Facility (SNF) claims include Resource Utilization Groups (RUGs) that identify whether a beneficiary received therapy and the range of therapy minutes provided. For example, SNF claims with a RUG that begins with "RU" or "RV" indicate that an ultra high or very high level of therapy was provided and that during a 7 day period, the beneficiary received 720 minutes or more, or 500 to 719 minutes of therapy, respectively. The higher the volume of therapy services provided, the higher the Medicare payment. OIG previous work found that SNFs billed for higher levels of therapy RUGs than were supported. OIG objective was to determine whether the therapy minutes associated with Highlands of Little Rock West Markham Holdings, LLC's claims containing ultra high or very high therapy RUGs were properly supported.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Highlands did not properly support all therapy minutes because it inappropriately included unskilled time for electrical simulation therapy for 14 of the sample claims. The errors occurred because the SNF staff did not understand that unskilled time should not be included in the Minimum Data Set (MDS) minutes. As a result, the SNF was overpaid $17,430 for the sample claims. Based on the sample results, OIG estimate the SNF was overpaid $25,494 during OIG audit period.

OIG recommended Highlands:

- Refund the $25,494 in questioned costs
- Educate staff to only include skilled minutes for MDS purposes.

OIG reported Highlands declined to comment on the draft report.

Work Plan #: A-06-18-08003 (November 2019)
Government Program: Medicare Parts A & B

Medicaid Nursing Home Life Safety Reviews

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 reviewed 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.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that New York did not ensure that selected nursing homes in the State that participated in the Medicare or Medicaid programs complied with CMS requirements for life safety and emergency preparedness. During OIG's onsite inspections, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 20 nursing homes that OIG reviewed. Specifically, OIG found 205 areas of noncompliance with life safety requirements related to building exits and fire barriers, fire detection and suppression systems, carbon monoxide detectors, hazardous storage, smoking policies and fire drills, and elevator and electrical equipment testing and maintenance. OIG found 219 areas of noncompliance with emergency preparedness requirements related to written emergency plans; emergency supplies and power; plans for evacuation, sheltering in place, and tracking residents and staff; emergency communications; and emergency plan training. As a result, nursing home residents at the 20 nursing homes were at increased risk of injury or death during a fire or other emergency

OIG recommended that the New York State Department of Health:

- follow up with the 20 nursing homes to ensure corrective actions have been taken regarding the life safety and emergency preparedness deficiencies identified in this report,
- work with CMS and other States' survey agencies to develop standardized life safety training for nursing home staff,
- Conduct more frequent surveys at nursing homes with a history of multiple high-risk deficiencies, and
- Instruct all nursing homes to install carbon monoxide detectors as required by New York State law and modify its survey procedures to include a check for carbon monoxide detectors.

Work Plan #: A-02-17-01027 (August 2019); A-09-18-03022; A-03-18-00005; W-00-18-35538; W-00-17-31525
Government Program: Medicare and Medicaid

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Home Health Service

Medicare Home Health Agency Provider Compliance Audits

Under the Medicare home health prospective payment system (PPS), the Centers for Medicare & Medicaid Services pays home health agencies (HHAs) a standardized payment for each 60-day episode of care that a beneficiary receives. The PPS payment covers intermittent skilled nursing and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. OIG's prior audits of home health services identified significant overpayments to HHAs. These overpayments were largely the result of HHAs improperly billing for services to beneficiaries who were not confined to the home (homebound) or were not in need of skilled services.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Mission Home Health of San Diego, Inc. (A-09-18-03008)

OIG reported that Mission Home Health did not comply with Medicare billing requirements for 32 home health claims that OIG audited. For these claims, Mission Home Health received overpayments of $61,718 for services provided during OIG's audit period. Specifically, Mission Home Health incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, (3) claims that were assigned incorrect payment codes, and (4) claims for which documentation was inadequate to support the services provided. These errors occurred primarily because Mission Home Health did not have adequate procedures to prevent the incorrect billing of Medicare claims. Based on OIG's sample results, OIG estimated that Mission Home Health received overpayments of at least $5.9 million for OIG's audit period.

OIG recommended that Mission Home Health: (1) refund to the Medicare program the portion of the estimated $5.9 million overpayment for claims incorrectly billed that are within the reopening period, (2) for the remaining portion of the estimated $5.9 million overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, and (4) strengthen its procedures to ensure the correct billing of Medicare claims.

[NEW] Condado Home Care Program, Inc. (A-02-17-01022)

OIG reported that Condado did not comply with Medicare billing requirements for 14 home health claims that OIG audited. Specifically, Condado incorrectly billed Medicare for (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, (3) incorrect Health Insurance Prospective Payment System payment codes, or (4) services provided under a plan of care that did not meet Medicare requirements. These errors occurred because Condado did not have adequate procedures in place to prevent the incorrect billing of Medicare claims within selected risk areas. Based on OIG's sample results, OIG estimated that Condado received overpayments of at least $97,210 for the audit period.

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OIG made several recommendations to Condado, including that it: (1) refund to the Medicare program the portion of the estimated $97,210 in overpayments for claims incorrectly billed that are within the four-year claim reopening period, (2) exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule, and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside the reopening period.

Residential Home Health (A-05-16-00063)

OIG reported that Residential did not comply with Medicare billing requirements for 11 of the 100 home health claims that OIG reviewed. For these claims, Residential received overpayments of $16,927 for services provided in calendar years (CYs) 2014 and 2015. Specifically, Residential incorrectly billed Medicare for beneficiaries who: (1) were not homebound or (2) did not require skilled services. Based on OIG's sample results, OIG estimated that Residential received overpayments of at least $2 million in CYs 2014 and 2015. All the incorrectly billed claims are now outside of the Medicare reopening period.

OIG recommended Residential exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with OIG's recommendations. OIG also recommended that Residential strengthen its procedures to ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, and (2) beneficiaries are receiving only reasonable and necessary skilled services.

Palos (A-05-17-00022)

OIG found that Palos did not comply with Medicare billing requirements for 16 home health claims. For these claims, Palos received overpayments of $22,428 for services provided in calendar years (CYs) 2015 and 2016. Specifically, Palos incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries that did not require skilled services, or (3) incorrect Health Insurance Prospective Payment System payment codes. Based on OIG's sample results, OIG estimated that Palos received overpayments of at least $680,884 for CYs 2015 and 2016.

OIG made several recommendations to Palos, including: (1) refund the portion of the estimated $680,884 in overpayments for claims incorrectly billed that are within the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period.

Angels Care Home Health (A-07-16-05093)

OIG found that Angels Care did not comply with Medicare billing requirements for 29 of the 72 home health claims paid in CYs 2014 or 2015 that OIG reviewed. For these claims, Angels Care received overpayments of $57,148. Specifically, Angels Care incorrectly billed Medicare because: (1) beneficiaries were not homebound, (2) beneficiaries did not require skilled services, or (3) claims were assigned with incorrect Health Insurance Prospective Payment System payment codes. Based on OIG's sample results, OIG estimated that during CYs 2014 and 2015 the Angels Care received overpayments totaling $3.8 million.

OIG recommended that Angels Care: (1) refund to the Medicare program the portion of the $3.8 million in estimated overpayments received during CYs 2014 and 2015 for claims incorrectly billed and within the reopening and recovery periods, (2) for the rest of the $3.8 million in estimated overpayments for claims that are outside the 4-year reopening period,

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exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation, and (4) strengthen controls to ensure full compliance with requirements for billing home health services.

Mederi Caretenders (A-07-16-05092)

OIG found that Mederi Caretenders did not comply with Medicare billing requirements for 21 home health claims paid in CYs 2014 or 2015. For these claims, Mederi Caretenders received overpayments of $31,428. Specifically, Mederi Caretenders incorrectly billed Medicare because: (1) beneficiaries were not homebound, (2) beneficiaries did not require skilled services, (3) one claim was assigned with an incorrect Health Insurance Prospective Payment System billing code, or (4) one claim was not adequately documented. Based on OIG's sample results, OIG estimated that during CYs 2014 and 2015 the Mederi Caretenders received overpayments totaling at least $1.26 million.

OIG recommended that Mederi Caretenders: (1) refund to the Medicare program the portion of the $1.26 million in estimated overpayments received during CYs 2014 and 2015 for claims incorrectly billed that are within the reopening and recovery periods, (2) exercise reasonable diligence to identify and return any additional similar overpayments outside of the 4-year claim-reopening period, in accordance with the 60-day rule, and (3) strengthen its controls to ensure full compliance with Medicare requirements for billing home health services.

Metropolitan **(**A-02-16-01001)

OIG found that Metropolitan did not comply with Medicare billing requirements for 11 of the 100 home health claims that OIG reviewed. For these claims, Metropolitan received overpayments of $34,514 for services provided during CYs 2013 and 2014. Specifically, Metropolitan incorrectly billed Medicare for beneficiaries that were not homebound or did not require skilled services. In addition, Metropolitan received reimbursement for claims for which the services were not supported by documentation. Based on OIG's sample results, OIG estimated that Metropolitan received overpayments of at least $2.9 million for the audit period. All the incorrectly billed claims are now outside of the Medicare reopening period; therefore, OIG did not recommend recovery of the overpayments.

OIG recommended that Metropolitan exercised reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with OIG recommendations. OIG also recommended that Metropolitan strengthen its procedures to ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, (2) beneficiaries are receiving only reasonable and necessary skilled services, and (3) reimbursement for services comply with Medicare documentation requirements.

Great Lakes (A-05-16-00057)

OIG found that Great Lakes did not comply with Medicare billing requirements for 38 of the 100 home health claims that OIG reviewed. For these claims, Great Lakes received overpayments of $64,114 for services provided in calendar years (CYs) 2014 and 2015. Specifically, Great Lakes incorrectly billed Medicare for beneficiaries who: (1) were not homebound, and (2) did not require skilled services. Based on OIG sample results, OIG estimated that Great Lakes received overpayments of $10.5 million in CYs 2014 and 2015.

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OIG made several recommendations to Great Lakes, including that it: (1) refund to the Medicare program the portion of the estimated $10.5 million in overpayments for claims incorrectly billed for the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, and (4) strengthen its procedures.

EHS (A-05-16-00055)

OIG reported that EHS did not comply with Medicare billing requirements for 35 of the 100 home health claims that OIG reviewed. For these claims, EHS received overpayments of $55,303 for services provided in calendar years (CYs) 2014 and 2015. Specifically, EHS incorrectly billed Medicare for beneficiaries who: (1) were not homebound or (2) did not require skilled services. Based on OIG sample results, OIG estimated that EHS received overpayments of at least $7.5 million in CYs 2014 and 2015.

OIG made several recommendations to EHS, including that it: (1) refund to the Medicare program the portion of the estimated $7.5 million in overpayments for claims incorrectly billed for the reopening period, (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period, (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period, and (4) strengthen its procedures.

Excella (A-01-16-00500)

OIG found that Excella did not comply with Medicare billing requirements for 41 of the 100 home health claims that OIG reviewed. For these claims, Excella received overpayments of $129,520 for services provided in calendar years (CYs) 2013 and 2014. Specifically, Excella incorrectly billed Medicare because beneficiaries: (1) were not homebound or (2) did not require skilled services. Based on OIG sample results, OIG estimated that Excella received overpayments of at least $6.6 million for the CY 2013 and CY 2014 period. All the incorrectly billed claims are now outside of the Medicare reopening period; therefore, OIG did not recommend recovery of the overpayments.

OIG recommended that Excella exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with OIG recommendations. OIG also recommended that Excella strengthen its procedures to ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, and (2) beneficiaries are receiving only reasonable and necessary skilled services.

Work Plan #: A-09-18-03008 (August 2020); A-02-17-01022 (August 2020); A-05-16-00063 (April 2020); A-05-17-00022 (December 2019); A-07-16-05093 (October 2019); A-07-16-05092 (August 2019); A-02-16-01001 (May 2019); A-05-16-00057 (May 2019); A-05-16-00055 (May 2019); A-01-16-00500 (May 2019); W-00-19-35712; W-00-16-35712; W-00-16-35501; W-00-17-35712
Government Program: Medicare Parts A & B

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Provider

CMS Could Have Saved $192 Million by Targeting Home Health Claims for Review

Under the prospective payment system (PPS), Medicare pays home health agencies (HHAs) for each 60-day episode of care that a beneficiary receives, called a payment episode. During OIG's audit period, if an HHA provided four or fewer visits in a payment episode, Medicare paid the HHA a standardized per-visit payment. Claims for these types of payments are called Low Utilization Payment Adjustment (LUPA) claims. Once a fifth visit was provided during the payment episode (i.e., above the LUPA threshold), Medicare paid an amount for the services provided that was, in general, substantially higher than the per-visit payment amount. Because of the large payment increase starting with the fifth visit, HHAs have an incentive to improperly bill claims with visits slightly above the LUPA threshold.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for 4 claims there was no documentation available to make a compliance determination. Another 25 claims did not comply with requirements. As a result, Medicare improperly paid HHAs for a portion of the payment episode (14 claims) and for the full payment episode (11 claims), totaling $41,613. These improper payments occurred because the Medicare administrative contractors (MACs) did not analyze claim data or perform risk assessments to target for additional review for those claims with visits slightly above the LUPA threshold of four visits. Based on OIG's sample results, OIG estimated that Medicare overpaid HHAs nationwide $191.8 million for OIG's audit period.

OIG recommended that CMS (1) direct the MACs to recover the $41,613 in identified overpayments made to HHAs for the sampled claims; (2) require the MACs to perform data analysis and risk assessments of claims with visits slightly above the applicable LUPA threshold and target these claims for additional review; and (3) instruct the MACs to educate HHA providers on properly billing for home health services with visits slightly above the applicable LUPA threshold, which could have saved Medicare as much as $191.8 million during OIG's audit period.

Work Plan #: A-09-18-03031 (July 2020)
Government Program: Medicare Parts A & B

Iowa Inadequately Monitored Its Medicaid Health Home Providers, Resulting in Tens of Millions in Improperly Claimed Reimbursement

The Medicaid "health home" option allows states to create programs that provide care coordination and care management for Medicaid beneficiaries with chronic health conditions. Health homes are not physical spaces. Rather, they are a healthcare model based on the idea that several providers can work together to coordinate and manage beneficiaries' care and, in doing so, provide quality care at a reasonable cost. For federal fiscal year 2016, states claimed Federal Medicaid reimbursement for health home services totaling $750 million ($431 million federal share). Iowa's program accounted for three percent of the Federal share. OIG's objective was to determine whether Iowa's claims for Medicaid reimbursement for payments made to health home providers complied with federal and state requirements.

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported for 62 payments, Iowa improperly claimed Federal Medicaid reimbursement for payments made to health home providers that did not comply with federal and state requirements. These 62 improper payments primarily involved deficiencies in documentation. Specifically, Iowa's health home providers did not document core services, integrated health home outreach services, diagnoses, and enrollment with providers. In addition, Iowa's providers did not maintain documentation to support higher payments for intense integrated health home services and did not ensure that beneficiaries had full Medicaid benefits. The improper payments occurred because Iowa did not adequately monitor providers for compliance with certain federal and state requirements. Based on OIG's sample results, OIG estimated that Iowa improperly claimed at least $37.1 million in Federal Medicaid reimbursement for payments made to health home providers.

OIG recommended Iowa refund $37.1 million to the Federal Government. OIG also recommended that Iowa improve its monitoring of the health home program to ensure that health home providers comply with federal and state requirements for documenting the services for which the providers billed and received payments. OIG also recommended that Iowa revise its State Medicaid plan to define documentation requirements and that Iowa educate providers on these requirements.

Work Plan #: A-07-18-04109 (April 2020)
Government Program: Medicaid

High-Risk, Error-Prone HHA Providers Using HHA Historical Data

For Calendar Year 2016, Medicare paid home health agencies (HHAs) about $18.2 billion for home health services. CMS's Comprehensive Error Rate Testing (CERT) program determined that the 2016 improper payment error rate for home health claims was 42 percent, or about $7.7 billion. Using data from the CERT program, OIG identified the common characteristics of at risk HHA providers that could be used to target pre- and post-payment review of claims.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Medicare paid more than $4 billion to 87 high-risk HHAs. OIG found that about 78 percent of the CERT-reviewed payments to these HHAs were improper. The majority of HHA errors were associated with the face-to-face (FTF) evaluation requirement or physician certification and recertification of patients' eligibility.

OIG recommended that, given the amount of Medicare dollars paid to these providers and the high error rate observed in the CERT sample, focusing oversight on high-risk HHAs and the prevalent types of errors could significantly improve the effectiveness of CMS's efforts to reduce both HHA improper payments and the CERT error rate.

Work Plan #: A-05-17-00035 (August 2019); W-00-17-35800
Government Program: Medicare Parts A & B

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Provider

Administration for Community Living Oversight of Independent Living Programs

Administration for Community Living (ACL) sponsors independent living programs that support community living and independence for people with disabilities across the Nation. Among its other oversight responsibilities, ACL is required under Title VII of the Rehabilitation Act of 1973 (the Act), as amended, to conduct onsite compliance reviews of at least (1) 15 percent of Centers for Independent Living that receive funds under section 722 of the Act and (2) one-third of designated State units that receive funding under section 723 of the Act. OIG reviewed ACL's oversight activities, including its plan for compliance with the onsite review requirements. OIG also reviewed any other oversight activities that ACL plans to use to monitor independent living programs nation-wide.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that ACL did not appropriately oversee the activities of the two independent living programs. Specifically, ACL did not conduct any onsite compliance reviews of either the Centers for Independent Living program or Independent Living Services program since beginning its oversight of the programs in July 2014.

OIG recommended ACL determine whether it can allocate its funds differently to enable onsite compliance reviews, seek additional department funding or resources to conduct the onsite compliance reviews, and perform required onsite compliance reviews of independent living programs.

Work Plan #: A-05-18-00034 (August 2019); W-00-18-59432
Government Program: Medicaid

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Protecting Medicare Hospice Beneficiaries from Harm

OIG produced this study as a companion to *Trends in Hospice Deficiencies and Complaints* (also included in this SunHawk summary) in which OIG determined the extent and nature of hospice deficiencies and complaints and identify trends. For this study, OIG used the survey reports to provide more detail about poor-quality care that resulted in harm to beneficiaries. Additionally, OIG described specific instances of harm to Medicare hospice beneficiaries and identified the vulnerabilities in Medicare's process for preventing and addressing harm.

SunHawk Summary of OIG Evaluation Findings and Recommendations

Protecting Medicare Hospice Beneficiaries from Harm (OEI: 02-17-00021)

OIG's report featured 12 cases of harm to beneficiaries receiving hospice care caused by multiple vulnerabilities including insufficient reporting requirements for hospices, limited reporting requirements for surveyors, and barriers that beneficiaries and caregivers face in making complaints. Also, these hospices did not face serious consequences for the harm described in this report. Specifically, surveyors did not always cite immediate jeopardy in cases of significant beneficiary harm and hospices' plans of correction are not designed to address underlying issues. In addition, CMS cannot impose penalties, other than termination, to hold hospices accountable for harming beneficiaries.

OIG recommended that CMS seek statutory authority to establish additional, intermediate remedies for poor hospice performance. OIG also recommended that CMS should (1) strengthen requirements for hospices to report abuse, neglect, and other harm; (2) ensure that hospices are educating their staff to recognize signs of abuse, neglect, and other harm; (3) strengthen guidance for surveyors to report crimes to local law enforcement; (4) monitor surveyors' use of immediate jeopardy citations; and (5) improve and make user-friendly the process for beneficiaries and caregivers to make complaints.

Trends in Hospice Deficiencies and Complaints (OEI: 02-17-00020)

OIG reported that over 300 hospices had at least one serious deficiency or at least one substantiated severe complaint in 2016, which OIG considered to be poor performers. These hospices represent 18 percent of all hospices surveyed nation-wide in 2016.

OIG recommended CMS should (1) expand the deficiency data that accrediting organizations report to CMS and use this data to strengthen its oversight of hospices; (2) take the steps necessary to seek statutory authority to include information from accrediting organizations on Hospice Compare, CMS's website that contains limited information about individual hospices; (3) include on Hospice Compare the survey reports from state agencies; (4) include on Hospice Compare the survey reports from accrediting organizations, once authority is obtained; (5) educate hospices about common deficiencies and those that pose particular risks to beneficiaries; and (6) increase oversight of hospices with a history of serious deficiencies.

Work Plan #: OEI: 02-17-00021 (July 2019); OEI: 02-17-00020 (July 2019)
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Duplicate Drug Claims for Hospice Beneficiaries

Medicare Part A pays providers a daily per diem amount for everyone who elects hospice coverage, and part of the per diem rate is designed to cover the cost of drugs related to the terminal illness. Accordingly, Medicare Part D drug plans should not pay for prescription drugs related to a hospice beneficiary's terminal illness because the drugs are already included in the Part A hospice benefit. Previous OIG work found that Medicare may have paid twice for prescription drugs for hospice beneficiaries, once under the Part A per diem rate and again under Part D. OIG followed up on this work and reviewed the appropriateness of Part D drug claims for individuals who are receiving hospice benefits under Part A. OIG also determined whether Part D continued to pay for prescription drugs that should have been covered under the per diem payments made to hospice organizations.

SunHawk Summary of OIG Audit Findings and Recommendations

Based on OIG's sample results, OIG estimated that the Part D total cost was $160.8 million for drugs that hospice organizations should have paid for. Additionally, although hospices told us they should not have paid for the drugs associated with the remaining $261.9 million of the $422.7 million total cost, a review of CMS communications with hospices and sponsors between 2012 and 2016 indicates otherwise—hospice organizations or hospice beneficiaries likely should have paid for many of these drugs, not Part D.

OIG recommended that CMS should work directly with hospices to ensure that they are providing drugs covered under the hospice benefit. In addition, OIG recommended that CMS should develop and execute a strategy to ensure that Part D does not pay for drugs that should be covered by the Part A hospice benefit, which would save at least an estimated $160.8 million a year in Part D total cost, with potentially much higher annual savings associated with the drugs that hospices said they were not responsible for providing

Work Plan #: A-06-17-08004 (August 2019); W-00-17-35802
Government Program: Medicare Part D - Prescription Drug Program

SUNHAWK CONSULTING

Provider

Medical Equipment & Supplies

[NEW] CMS Generally Met Requirements for the DMEPOS Competitive Bidding Program Round 1 Recompete

The Medicare Improvements for Patients and Providers Act of 2008 contains a broad mandate requiring OIG to assess, through a post-award audit, survey, or otherwise, the process used by the Centers for Medicare & Medicaid Services (CMS) to conduct the competitive bidding and subsequent pricing determinations that are the basis for the pivotal bid amounts and single-payment amounts (SPAs) under Rounds 1 and 2 of the Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program (the Program). OIG's objective was to determine whether CMS selected DMEPOS suppliers, calculated the SPAs, and monitored the suppliers for the Round 1 Recompete in accordance with its established Program procedures and applicable Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS did not consistently follow its established procedures and applicable Federal requirements for selecting suppliers during the bid process for 6 of the 225 winning suppliers. This inconsistency affected 3 of the 30 sampled SPAs. Specifically, CMS awarded contracts to five suppliers that did not meet financial statement requirements and one supplier that did not have the applicable state license in one competition. Additionally, CMS did not monitor suppliers in accordance with established procedures and federal requirements for another seven suppliers that did not maintain the applicable license, as required by their contracts for the first six months of 2014. On the basis of OIG's sample, OIG estimated that CMS paid suppliers $24,054 more than they would have received without any errors, or less than 0.03 percent of the $73 million paid under the Round 1 Recompete during the first six months of 2014.

OIG recommended that CMS take specific actions, as described in this report, to ensure that suppliers meet financial documentation requirements and obtain and maintain the required licenses.

Work Plan #: A-05-16-00051 (August 2020)
Government Program: Medicare Parts A & B

Audits of Medicare Payments for Orthotic Braces

From January 1, 2016, through May 31, 2018 (audit period), Medicare paid $1.5 billion for knee, back, and ankle-foot braces (selected orthotic braces) provided to Medicare beneficiaries. Prior OIG audits and evaluations found that some suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) billed for orthotic braces that did not comply with Medicare billing requirements. During OIG's audit period, the Centers for Medicare & Medicaid Services found that orthotic braces were among the top 20 DMEPOS items with the highest improper payment rates.

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SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Visionquest Industries, Inc. (A-09-19-03010)

OIG found that Visionquest did not fully comply with Medicare requirements when billing for selected orthotic braces. For 67 sampled beneficiaries, Visionquest billed for orthotic braces that were not medically necessary. Based on OIG's sample results, OIG estimated that Visionquest received at least $2.5 million in unallowable Medicare payments for orthotic braces.

OIG recommended that Visionquest: (1) refund to the durable medical equipment Medicare administrative contractors the portion of the $2.5 million in estimated overpayments for claims that are within the four-year reopening period, (2) exercise reasonable diligence to identify and return any additional similar overpayments, and (3) obtain as much information from beneficiary medical records as it determines necessary to assure itself that claims for orthotic braces meet Medicare requirements for medical necessity.

[NEW] Desoto Home Health Care, Inc. (A-09-19-03021)

OIG reported that Desoto did not comply with Medicare requirements when billing for orthotic braces. For all 100 sampled beneficiaries, with payments totaling $143,714, Desoto billed for orthotic braces that were not medically necessary. These deficiencies occurred because Desoto did not obtain sufficient information from the beneficiaries' medical records to assure itself that the claims for orthotic braces met Medicare requirements for medical necessity. Based on OIG's sample results, OIG estimated that Desoto received at least $2.8 million in unallowable Medicare payments for orthotic braces.

OIG recommended that Desoto: (1) refund to the durable medical equipment Medicare administrative contractors $2.8 million in estimated overpayments for orthotic brace, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation, and (3) obtain as much information from beneficiary medical records as it determines necessary to assure itself that claims for orthotic braces meet Medicare requirements for medical necessity.

Freedom Orthotics, Inc (A-09-19-03012)

OIG found that for all 100 sampled beneficiaries, with payments totaling $165,306, Freedom billed for orthotic braces that were not medically necessary. These deficiencies occurred because Freedom did not obtain sufficient information from the beneficiaries' medical records to assure itself that the claims for orthotic braces met Medicare requirements for medical necessity. Based on OIG's sample results, OIG estimated that Freedom received at least $6.9 million in unallowable Medicare payments for orthotic braces.

OIG recommended that Freedom: (1) refund to the durable medical equipment Medicare administrative contractors $6.9 million in estimated overpayments for orthotic braces, (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation, and (3) obtain as much information from beneficiary medical records as it determines necessary to assure itself that claims for orthotic braces meet Medicare requirements for medical necessity.

Work Plan #: A-09-19-03010 (August 2020); A-09-19-03021 (August 2020); A-09-19-03012 (July 2020)
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Orthotic Braces - Reasonableness of Medicare Payments Compared to Amounts Paid by Other Payers

Since 2009, Medicare payments for orthotic braces, including back and knee, have more than doubled and almost tripled for certain types of knee braces. OIG determined the reasonableness of Medicare fee schedule amounts for orthotic braces. OIG compared Medicare payments made for orthotic braces to amounts paid by non-Medicare payers, such as private insurance companies, to identify potentially wasteful spending. OIG estimated the financial impact on Medicare and on beneficiaries of aligning the fee schedule for orthotic braces with those of non-Medicare payers.

SunHawk Summary of OIG Audit Findings and Recommendations

For CYs 2012 through 2015, OIG estimated that Medicare and beneficiaries paid $341.7 million more than select non-Medicare payers on 142 HCPCS codes and $4.2 million less than select non-Medicare payers on 19 HCPCS codes. Of the net $337.5 million payment difference, OIG estimated that Medicare paid $270 million and Medicare beneficiaries paid $67.5 million. OIG identified 95 of the 161 codes for which the Medicare allowable amounts could be adjusted using existing legislative authority to make those amounts comparable with payments made by select non-Medicare payers. For the remaining 66 codes, CMS would be required to seek new legislative authority to make those adjustments.

OIG recommended CMS (1) review the allowable amounts for 161 orthotic device HCPCS codes for which Medicare and beneficiaries paid an estimated $337.5 million more than select non-Medicare payers and adjust the allowable amounts, as appropriate, using regulations promulgated under existing legislative authority or if the allowable amounts cannot be adjusted using regulations promulgated under existing legislative authority, seek authority to align Medicare allowable amounts for these items with payments made by select non-Medicare payers; and (2) routinely review Medicare allowable amounts for new and preexisting orthotic devices to ensure that Medicare allowable amounts are in alignment with payments made by select non-Medicare payers or pricing trends.

Work Plan #: A-05-17-00033 (October 2019); W-00-17-35756
Government Program: Medicare Parts A & B

Medicare Improperly Paid Suppliers an Estimated $92.5 Million for Inhalation Drugs

Since 2010, the Centers for Medicare & Medicaid Services' (CMS's) Comprehensive Error Rate Testing (CERT) program has identified nebulizers and related drugs (i.e., inhalation drugs) among the top 20 suppliers with the highest improper Medicare payments. Prior OIG reviews (for calendar years (CYs) 2014 and 2015) found that the top two suppliers of inhalation drugs complied or generally complied with Medicare requirements. However, OIG's review of a third supplier (for CYs 2015 and 2016) found similar billing issues to those identified by the CERT program. These three suppliers received 56 percent of total Medicare payments for inhalation drugs during CY 2017 (audit period). OIG conducted this nation-wide review to determine whether the issues identified by the CERT program were primarily caused by suppliers that received the remaining 44 percent of payments, which OIG had not previously reviewed. OIG's objective was to determine whether the suppliers covered by OIG's review complied with Medicare requirements when billing for inhalation drugs.

Provider

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that for 39 claim lines, 22 suppliers did not comply with documentation requirements (the total below exceeds 39 because 2 claim lines had 2 deficiencies). Based on OIG's sample results, OIG estimated that $92.5 million paid to suppliers was unallowable for Medicare reimbursement. Medicare contractor oversight was not sufficient to ensure that suppliers complied with documentation requirements.

OIG recommended that CMS instruct the Medicare contractors to recover $36,825 in overpayments for the 39 unallowable claim lines and notify the 22 suppliers associated with the 39 claim lines with potential overpayments of $36,825 so that those suppliers can exercise reasonable diligence to investigate and return any identified overpayments. OIG also made three procedural recommendations to CMS (detailed in the report), including working with the Medicare contractors to expand their review of inhalation drug claims and to provide additional training, which could have saved Medicare an estimated $92.5 million for CY 2017.

Work Plan #: A-09-18-03018 (October 2019)
Government Program: Medicare Parts A & B

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Provider

Accountable Care Organizations (ACOs)

Sunshine ACO, LLC, Generally Reported Complete and Accurate Data on Quality Measures Through the CMS Web Portal, but There Were a Few Reporting Deficiencies That Did Not Affect the Overall Quality Performance Score

The Affordable Care Act established the Medicare Shared Savings Program (MSSP). Accountable Care Organizations (ACOs) in the MSSP may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if they reduce healthcare costs and satisfy the quality performance standard for their assigned beneficiaries. As part of the standard, ACOs must report to CMS complete and accurate data on all quality measures. For performance year (PY) 2016, ACOs reported more than half of the quality measures using the designated CMS web portal. If the reported data were not complete and accurate, the shared savings payments could have been affected. This vulnerability led OIG to select two ACOs that had consistently received shared savings payments to perform an initial risk assessment of ACOs' reporting of data on quality measures through the CMS web portal.

SunHawk Summary of OIG Audit Findings and Recommendations

Sunshine ACO, LLC. (A-09-18-03019)

OIG found that for 11 sampled beneficiary-measures, Sunshine did not comply with requirements. Specifically, the medical records did not support that the beneficiaries (1) should have been either included in or removed from the measure population based on the exclusion criteria or (2) satisfied the conditions of the quality measures. Further, the medical records did not support the reported measurement values or that the reported measurement values were the most recent for the beneficiaries. Instead, the records supported different measurement values that would have still satisfied the conditions of the quality measures. These reporting deficiencies, which did not affect Sunshine's overall quality performance score, occurred because according to Sunshine officials, the ACO staff made clerical errors when entering the data and did not perform a thorough review of the beneficiaries' medical records to confirm that (1) the beneficiaries should have been included in or removed from the measure population for the Colorectal Cancer Screening measure or (2) the reported measurement values were the most recent for the Controlling High Blood Pressure measure and the Diabetes: Hemoglobin A1c Poor Control measure.

This report contains no recommendations.

West Florida ACO, LLC. (A-09-18-03003)

OIG found that for 13 sampled beneficiary-measures, West Florida did not comply with requirements. Specifically, the medical records did not support that the beneficiaries (1) should have been either included in or removed from the measure population based on the exclusion criteria or (2) satisfied the conditions of the quality measures. Further, the medical records did not support the reported measurement values or the reported "Patient Reason" exception. Instead, the records supported (1) different measurement values that would have still satisfied the conditions of the quality measure or (2) a "Medical Reason" exception that would have still removed the beneficiary from the measure population. These reporting deficiencies, which did not affect West Florida's overall quality performance score, occurred because according to West Florida officials, the ACO participant staff (1) made clerical errors when entering the data and (2)

presumed that the beneficiaries did not have an active diagnosis of depression and did not realize that the beneficiaries should have been removed for meeting the exclusion criteria for the depression screening measure. In addition, according to these officials, physicians find it difficult to distinguish between the two exception reasons and, based on a physician's interpretation, either the "Patient Reason" exception or the "Medical Reason" exception may apply.

OIG recommend that West Florida (1) ensure that it accurately reports all data on quality measures through the CMS web portal and (2) clarify with CMS its understanding of the exclusion criteria for a beneficiary to be removed from the measure population and the difference between the "Patient Reason" exception and the "Medical Reason" exception.

Work Plan #: A-09-18-03019 (October 2019); A-09-18-03003 (August 2019)

Government Program: Medicare Parts A & B

Accountable Care Organizations' Strategies Aimed at Reducing Spending and Improving Quality

The Medicare Shared Savings Program (MSSP) introduced accountable care organizations (ACOs) into the Medicare Program to promote accountability of hospitals, physicians, and other providers for a patient population; coordinate items and services; encourage investment in infrastructure; and redesign care processes for high-quality and efficient service delivery. OIG identified ACOs' strategies aimed at reducing spending and improving quality. Specifically, described ACOs' strategies intended to reduce spending and improve care in different service areas, such as hospitals and nursing homes. OIG also described strategies ACOs are using to work with physicians and engage beneficiaries; manage the care of beneficiaries needing high-cost, complex care; address behavioural health and social needs; and use data and technology.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that ACOs reported a number of successful strategies in reducing Medicare spending and improving quality of care for patients. These strategies should inform CMS's broader efforts to transform the healthcare system from fee-for-service to value-based care.

OIG recommended that CMS take the following actions to support efforts to reduce unnecessary spending and improve quality of care for patients: (1) review the impact of programmatic changes on ACOs' ability to promote value-based care; (2) expand efforts to share information about strategies that reduce spending and improve quality among ACOs and more widely with the public; (3) adopt outcome-based measures and better align measures across programs; (4) assess and share information about ACOs' use of the skilled nursing facility (SNF) 3-day rule waiver and apply these results when making changes to the Shared Savings Program or other programs; (5) identify and share information about strategies that integrate physical and behavioral health services and address social determinants of health; (6) identify and share information about strategies that encourage patients to share behavioral health data; and (7) prioritize ACO referrals of potential fraud, waste, and abuse.

Work Plan #: OEI: 02-15-00451 (July 2019)
Government Program: Medicare Parts A & B

Behavioral Health

On-Site Psychological Services, P.C.: Audit of Medicare Payments for Psychotherapy Services

Medicare paid approximately $2.2 billion for psychotherapy services provided to Medicare beneficiaries nationwide during calendar years 2017 and 2018. Prior OIG audits and reviews found that Medicare had made millions of dollars in improper payments for mental health services, including psychotherapy services.

SunHawk Summary of OIG Audit Findings and Recommendations

On-Site Psychological Services, P.C. (A-02-19-01012)

OIG found that 111 claims for psychotherapy services did not comply with Medicare billing requirements. Specifically, OIG reported that beneficiaries' treatment plans did not comply with Medicare requirements, therapeutic maneuvers were not specified in beneficiaries' treatment notes (9 claims), and treatment notes did not support services billed (5 claims). OIG also identified potential quality-of-care issues related to all 120 claims for psychotherapy services: beneficiaries' treatment plans did not document if a beneficiary's condition improved or had a reasonable expectation of improvement (111 claims) and treatment notes were "signed" with digital images of clinicians' signatures (109 claims). Based on OIG's sample results, OIG estimated that On-Site received at least $3.3 million in Medicare overpayments for psychotherapy services. These deficiencies allegedly occurred because On-Site's management oversight did not ensure that treatment plans were maintained or contained all required elements, therapeutic maneuvers utilized by clinicians were properly documented in treatment notes, and reliable treatment notes were maintained to support services billed. In addition, on-site also did not have controls in its electronic recordkeeping system to allow for electronic signatures.

OIG recommended that On-Site (1) refund to the Medicare program the estimated $3.3 million overpayment; (2) based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; (3) strengthen its management oversight to ensure that it properly maintains treatment plans that contain all required elements, therapeutic maneuvers utilized by clinicians are properly documented in treatment notes, and it properly maintains reliable treatment notes to support services billed; and (4) implement controls for authenticating signatures on treatment notes.

Grant Desert Psychiatric Services (A-09-19-03018)

OIG found that 99 services did not comply with the requirements (the total below exceeds 99 because 29 services had more than 1 deficiency): As a result, Grand Desert received $5,173 in unallowable Medicare payments. On the basis of OIG's sample results, OIG estimated that at least $421,272 were unallowable for Medicare reimbursement, or 93 percent of the $450,663 paid to Grand Desert for psychotherapy services.

OIG recommended that Grand Desert (1) refund to the Medicare contractor $421,272 in estimated overpayments for psychotherapy services; (2) implement policies and procedures to ensure that psychotherapy services billed to Medicare are adequately documented, including the time spent on those services; (3) strengthen management oversight and review

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Medicare claims to ensure that psychotherapy services billed to Medicare meet incident-to requirements; (4) improve its billing system to ensure that Medicare claims identify the correct provider of psychotherapy services; and (5) strengthen management oversight to ensure that psychotherapy services billed to Medicare were actually provided and have supporting documentation.

Oceanside Medical Group (A-09-18-03004)

OIG found that Oceanside did not comply with Medicare requirements when billing for psychotherapy services. Specifically, none of the 100 sampled beneficiary days, consisting of 103 psychotherapy services, complied with Medicare requirements: psychotherapy was not provided (52 services), psychotherapy time was not documented (49 services), and adequate supporting documentation was not provided (2 services). As a result, Oceanside received $5,317 in unallowable Medicare payments. Based on OIG's sample results, OIG estimated that Oceanside received at least 2.6 million in unallowable Medicare payments for psychotherapy services. These overpayments occurred because Oceanside did not have policies and procedures or effective management oversight to ensure that psychotherapy services billed to Medicare were provided, adequately documented, and correctly billed.

OIG recommended that Oceanside (1) refund to the Medicare program the portion of the estimated $2.6 million overpayment for claims that are within the reopening period; (2) for the remaining portion of the estimated 2.6 million overpayment for claims that are outside of the reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and (4) implement policies and procedures and strengthen management oversight to ensure that psychotherapy services billed to Medicare are actually provided, adequately documented, and correctly billed.

Work Plan #: A-02-19-01012 (July 2020); A-09-19-03018 (April 2020); A-09-18-03004 (August 2019)
Government Program: Medicare A & B

An Estimated 87 Percent of Inpatient Psychiatric Facility Claims with Outlier Payments Did Not Meet Medicare's Medical Necessity or Documentation Requirements

Under the inpatient psychiatric facility (IPF) prospective payment system (PPS), Medicare pays IPFs a standard per diem rate for inpatient services, modified for patient- and facility-level characteristics and length of stay. In addition, the IPF PPS includes an outlier payment policy that makes an additional payment in cases with unusually high costs to limit financial losses to IPFs. For this audit, OIG focused on claims that resulted in outlier payments because the number of those claims increased by 28 percent from fiscal year (FY) 2014 to FY 2015, and total Medicare payments for those claims (including the outlier payment portion) increased from $450 million to $534 million (19 percent).

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SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that CMS paid 25 claims that did not meet Medicare medical necessity requirements for some or all days of the stay. Based on OIG sample results, OIG estimated that Medicare overpaid IPFs $93 million for FYs 2014 and 2015 for stays that were noncovered or partially noncovered and resulted in outlier payments. However, if the patients had been treated in different settings, Medicare might have covered those treatments. In addition, 142 claims had missing or inadequate medical record elements, including physician certifications. Of those 142 medical records, 12 did not clearly support that the IPF had protected the patient's right to make informed decisions regarding care. OIG estimated that 87 percent of IPF claims for FYs 2014 and 2015 with outlier payments did not meet Medicare medical necessity or medical record requirements. CMS oversight activities were not adequate to prevent or detect the IPFs' errors. Finally, OIG identified three additional areas of concern: (1) outlier payments may have been made for stays that were not unusually costly, (2) beneficiaries used lifetime reserve days to help pay for days when they no longer required inpatient hospitalization but for the unavailability of appropriate posthospitalization placements, and (3) CMS did not track patient falls or fall rates at IPFs.

OIG made recommendations to (1) increase the number of post-payment reviews to provide more feedback to IPFs, (2) promulgate regulations on the patient's right to make informed decisions regarding care, (3) study the accuracy of the outlier payment methodology, (4) consider tracking patient falls or fall rates, (5) research whether the physician certification requirements are useful in preventing inappropriate payments and then take appropriate follow up action, (6) CMS require certifications to be in a specific format to aid in auditing, and (7) study the lifetime reserve day issue.

Work Plan #: A-01-16-00508 (April 2020)
Government Program: Medicare Parts A & B

Medicaid Claims for Opioid Treatment Program Services

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 determined whether selected State agencies complied with certain Federal and State requirements when claiming Medicaid reimbursement for OTP services.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that New York claimed Federal Medicaid reimbursement for OTP services that did not comply with federal and state requirements. 115 claims complied with Medicaid requirements, but 35 claims did not. In addition, 299 claims totaling $8,905 ($5,830 Federal share) were billed in error. Specifically, 220 claims were duplicate claims, and 79 claims were for services that the providers stated were not provided. Based on OIG sample results, OIG estimated that New York improperly claimed at least $39.3 million in Federal Medicaid reimbursement for OTP services during OIG audit period.

OIG recommended that New York (1) refund $39.3 million to the Federal Government, (2) ensure that providers comply with Federal and State requirements for providing and claiming reimbursement for OTP services, and (3) implement procedures to detect and prevent duplicate claims for OTP services.

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

Government Program: Medicaid

Assertive Community Treatment Program

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 determined 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.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that 50 of New Jersey's sampled claims did not comply with federal and state requirements. Of the 100 claims, 21 contained more than 1 deficiency. OIG found PACT program services provided were not adequately supported or documented (36 claims), plan of care requirements were not met (17 claims), PACT teams did not include staff from required clinical disciplines (8 claims), and providers did not obtain prior authorization for beneficiaries (5 claims), among other findings. OIG also identified potential quality-of-care issues related to PACT services. Specifically, PACT team psychiatrists associated with 33 of OIG sample claims did not provide the minimum amount of face-to-face psychiatric time required for their caseload. Also, despite defining the PACT program as rehabilitative, New Jersey did not require periodic reauthorizations or reevaluations of beneficiaries' program eligibility.

OIG recommended that New Jersey (1) refund $14.9 million to the Federal Government, (2) reinforce program guidance to PACT providers, (3) improve its monitoring of the PACT program, and (4) consider developing regulations for periodic reassessments to determine whether beneficiaries continue to require PACT services. maintain that OIG findings and recommendations, as revised, are valid.

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

Provider Shortages and Limited Availability of Behavioral Health Services in New Mexico's Medicaid Managed Care

Behavioral health services include treatment and support for mental health conditions-such as bipolar disorder-as well as substance abuse disorders, such as opiate dependence. Medicaid is the single largest payer for behavioral health services in the United States, and most states provide these services through Medicaid managed care plans. Existing research on managed care providers in general has found a shortage of those willing to participate in Medicaid networks, raising concerns that the number of providers may not be sufficient to meet the needs of the Medicaid population. This

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review of five states will determine the extent to which Medicaid managed care plans include behavioral health providers and whether enough providers are available to meet the needs of the Medicaid population.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that, despite the need for behavioral health services—which includes treatments and services for mental health and substance use disorders—many counties in New Mexico have few licensed behavioral health providers serving Medicaid managed care enrollees. These behavioral health providers are unevenly distributed across the State, with rural and frontier counties having fewer providers and prescribers per 1,000 Medicaid managed care enrollees. Further, a significant number of New Mexico's licensed behavioral health providers do not provide services to Medicaid managed care enrollees.

OIG recommended that the Centers for Medicare & Medicaid Services (CMS) identify states that have limited availability of behavioral health services and develop strategies and share information with them to ensure that Medicaid managed care enrollees have timely access to these services. OIG also recommended that the New Mexico Human Services Department expand New Mexico's behavioral health workforce that serves Medicaid managed care enrollees. It should also improve access to services by reviewing its access to care standards and by increasing access to transportation, access to broadband, and the use of telehealth. Lastly, it should improve the effectiveness of services by increasing adoption of electronic health records, identifying and sharing information about strategies to improve care coordination, expanding initiatives to integrate behavioral and primary healthcare, and sharing information about open-access scheduling and the Treat First Clinical Model.

Work Plan #: OEI: 02-17-00490 (September 2019)
Government Program: Medicaid

Many Medicaid-Enrolled Children Who Were Treated for ADHD Did Not Receive Recommended Follow-up Care

The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 (CHIPRA), Section 401: Child Health Quality Improvement Activities for Children enrolled in Medicaid or CHIP, requires the development of an initial core set of health care quality measures. The Centers for Medicare & Medicaid Services (CMS) has issued a core set of children's health care quality measures referred to as the Child Core Set that includes two behavioral health care measures related to follow-up care for children with attention deficit hyperactivity disorder (ADHD). Prior OIG work found that children enrolled in Medicaid who are prescribed psychotropic medications are not consistently or regularly monitored. OIG will evaluate the extent to which children diagnosed with ADHD and enrolled in Medicaid received follow-up care and psychosocial intervention.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG found that over 500,000 Medicaid-enrolled children who were newly prescribed an ADHD medication and over 3,500 children who were hospitalized with a primary diagnosis of ADHD did not receive follow-up care within the timeframes outlined in the national quality measures. Additionally, over 54,000 children did not receive any behavioral therapy as recommended by professional guidelines.

Provider

The Office of Inspector General (OIG) recommended that the Centers for Medicare & Medicaid Services (CMS) work toward improving health outcomes by developing strategies to increase the number of children who receive timely follow-up care for ADHD.

Work Plan #: OEI: 07-17-00170 (August 2019)
Government Program: Medicaid

Laboratory

[NEW] Medicare Laboratory Test Expenditures Increased in 2018, Despite New Rate Reductions

Effective in 2018, the Medicare program changed the way it sets payment rates for clinical diagnostic laboratory tests. CMS replaced the previous payment rates with new rates based on private payer data collected from labs. This is the first reform in three decades to Medicare's payment system for lab tests. As part of the same legislation reforming Medicare's payment system, Congress mandated that OIG monitor Medicare payments for lab tests as well as the implementation and effect of the new payment system for those tests.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that Medicare spent $7.6 billion for lab tests in 2018, a $459 million increase from $7.1 billion for 2017. Although payment rates for most tests decreased in 2018, savings that resulted from lower rates were overtaken by increased spending on other tests. Spending on genetic tests increased from $473 million in 2017 to $969 million in 2018 because of new and expensive tests entering the Clinical Laboratory Fee Schedule (CLFS), as well as an increase in the volume of existing genetic tests. Spending on certain chemistry tests also increased by $82 million in 2018 following the end of a discount on these tests. Finally, a one-time spending increase on some tests occurred in cases in which the national rate was higher than the local payment rates that it replaced.

OIG recommended that CMS seek legislative authority to establish a mechanism to control costs for automated chemistry tests. Although CMS does not currently have statutory authority to restore the discount that it had previously used to ensure efficient pricing for these tests, CMS should seek legislative change to regain such authority.

Work Plan #: OEI-09-19-00100 (August 2020)
Government Program: Medicare Parts A & B

Medicare Part B Payments for Laboratory Services

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. OIG reviewed Medicare payments for clinical laboratory services to determine laboratories' compliance with selected billing requirements. OIG focused on claims for clinical laboratory services that may be at risk for overpayments. For example, OIG's review focused 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.

SunHawk Summary of OIG Audit Findings and Recommendations

Novitas (A-06-17-04002)

OIG found that payments made by Novitas to providers for travel allowances for clinical diagnostic laboratory tests did not always comply with Medicare requirements. Specifically, 17 of the 93 claim lines in OIG stratified random sample complied with Medicare requirements, but 76 claim lines did not (some lines had multiple deficiencies). Novitas made payments to providers for (1) claims with incorrectly calculated prorated mileage, (2) claims using the incorrect clinical laboratory fee schedule rate, and (3) claims without sufficient documentation to support payment. Based on OIG sample results, OIG estimated that Novitas paid providers $2.4 million in travel allowances for clinical laboratory services that were not in accordance with Medicare requirements.

OIG recommended that Novitas (1) work with the Centers for Medicare & Medicaid Services to clarify guidance to providers, which could have resulted in savings totaling an estimated $2.4 million during OIG audit period; (2) educate providers on how to correctly calculate the prorated mileage for phlebotomy travel allowance payments; (3) educate providers on their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the incorrect payment rate; and (4) educate providers on their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments.

ProLab (A-06-16-02002)

OIG found that ProLab generally did not comply with Medicare requirements for billing travel allowances. Specifically, 35 claim lines complied with Medicare requirements and 65 claim lines did not (some lines had multiple deficiencies). ProLab did not (1) support prorated miles with documentation when multiple patients were served on a single trip, (2) resubmit claims when there was a retroactive change in the clinical laboratory fee schedule, and (3) have documentation to support specimen collections.

OIG recommended that ProLab (1) refund to the Medicare program the portion of the estimated $319,277 overpayment for claims incorrectly billed that are within the reopening period; (2) for the remaining portion of the estimated $319,277 overpayment for claims that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation; and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG's audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation.

Work Plan #: A-06-17-04002 (December 2019); A-06-16-02002 (October 2018)
Government Program: Medicare Part B

Wisconsin Physicians Service Needs Enhanced Guidance and Provider Education Related to Phlebotomy Travel Allowances

Medicare pays a specimen collection fee when it is medically necessary for a clinical laboratory technician to draw a specimen to perform a clinical diagnostic laboratory test. When a technician travels to a nursing facility or homebound patient and a specimen collection fee is payable, the Social Security Act provides for payment of a travel allowance. Prior

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work found that travel allowances were at risk of being overpaid. For this review, OIG focused on travel allowance payments for clinical diagnostic laboratory tests made by one Medicare administrative contractor (MAC), Wisconsin Physicians Service (WPS), because it was one of the largest payers of travel allowances in the Nation from January 1, 2015, through December 31, 2016 (audit period). The objective of OIG's review was to determine whether payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that 76 claim lines in OIG's stratified random sample that were reviewed complied with Medicare requirements, but 33 claim lines did not (some lines had multiple deficiencies). WPS made payments to providers for (1) claims with incorrectly calculated prorated mileage, (2) claims using the incorrect clinical laboratory fee schedule rate, and (3) claims without sufficient documentation to support payment. On the basis of OIG's sample results, OIG estimated that WPS paid providers $353,755 in travel allowances for clinical laboratory services that were not in accordance with Medicare requirements.

OIG recommended that WPS (1) work with the Centers for Medicare & Medicaid Services to clarify guidance to providers, which could have resulted in savings totaling an estimated $353,755 during OIG's audit period; (2) educate providers on how to correctly calculate the prorated mileage for phlebotomy travel allowance payments; (3) educate providers on their responsibility to bring any previously paid claims to their MAC's attention if they were paid using the wrong rate; and (4) educate providers on their responsibility to maintain adequate documentation to support payment for phlebotomy travel allowance payments.

Work Plan #: A-06-17-04005 (September 2019)
Government Program: Medicare Parts A & B

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Medicare's Oversight of Ambulatory Surgery Centers: A Data Brief

Medicare sets minimum health and safety requirements for ambulatory surgical centers (ASCs) through the Conditions of Participation. Centers for Medicare & Medicaid Services requires that ASCs become Medicare certified to show they meet these conditions. Previous OIG work found problems with Medicare's oversight system, including finding spans of five or more years between certification surveys for some ASCs, poor Centers for Medicare & Medicaid Services oversight of State survey agencies, and little public information on the quality of ASCs. OIG reviewed the frequency and deficiency findings of Medicare's certification surveys for ASCs.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that states largely met Medicare's requirements to survey 25 percent of non-deemed ASCs in fiscal year (FY) 2017, and nearly half met Medicare's requirement to have surveyed all ASCs within the prior 6 years. States cited 77 percent of non-deemed ASCs with at least one deficiency in their most recent survey, and one-quarter of ASCs had serious deficiencies. From FY 2013 to FY 2017, infection control deficiencies were the most frequently cited category of deficiency, making up about a fifth of all deficiencies.

OIG stated that the results of this new analysis can support CMS in further strengthening its oversight—particularly of the few states that are falling short of meeting its requirements. It can also help CMS focus on ASCs' recurring challenges in meeting health and safety requirements, especially for infection control.

Work Plan #: OEI: 01-15-00400 (September 2019)
Government Program: Medicare Parts A & B

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Telehealth

OIG Determines Telemedicine Services Require Improved Documentation

Medicaid telemedicine services are health services delivered via telecommunication systems. A Medicaid patient located at a patient site uses audio and video equipment to communicate with a physician or licensed practitioner located at a distant site. Medicaid views telemedicine services as a cost-effective alternative to the more traditional face-to-face way of providing medical care. OIG's objective for these audits was to determine whether selected states complied with federal and state requirements when claiming federal reimbursement for telemedicine services.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Illinois (A-05-18-00028)

OIG reported that 28,647 Medicaid fee-for-service telemedicine payments in OIG's population, 6,260 payments were unallowable. For 6,205 of the unallowable payments, the same provider was paid for both the originating site and distant site fee. Fifty-three claims were inaccurately coded as both originating and distant site fees. The remaining two unallowable payments were payments for the same originating site fee in the same day. This noncompliance occurred because Illinois did not give providers formal training on telemedicine billing requirements or adequately monitor compliance. Based on OIG's testing, OIG determined that Illinois made unallowable payments of $198,124 ($124,812 federal share) during OIG's audit period.

OIG recommended that Illinois refund $124,812 to the Federal Government, give providers formal training on telemedicine billing requirements, and enhance the monitoring of provider compliance by conducting periodic reviews of telemedicine payments for compliance with billing requirements.

Texas (A-06-18-05001)

OIG found that the provider submitted a claim for a professional service with the telemedicine modifier, however, OIG determined that it was a face to face visit and not a telemedicine service. OIG reported that this reportedly incorrect billing did not affect the Medicaid payment amount that the provider received.

This OIG report included no recommendations.

South Carolina (A-04-18-00122)

OIG reported that South Carolina made 97 telemedicine payments that were not in accordance with Federal and State requirements and were therefore unallowable. For 95 unallowable payments, the providers documented neither the start and stop times nor the consulting site location of the medical service. The remaining two unallowable payments were for in-office consultations, not telemedicine services. This noncompliance occurred because South Carolina did not give providers formal training on telemedicine documentation requirements or adequately monitor compliance. Based on OIG's sample results, OIG estimated that 96 percent of South Carolina's Medicaid fee-for service telemedicine payments were unallowable. OIG also estimated that unallowable payments totaled at least $2.1 million ($1.5 million Federal share) during OIG audit period.

OIG recommended that South Carolina refund $1.5 million to the Federal Government, give providers formal training on telemedicine documentation requirements, and enhance the monitoring of provider compliance by conducting periodic reviews of telemedicine payments for compliance with documentation requirements.

Work Plan #: A-05-18-00028 (August 2020); A-06-18-05001 (June 2020); A-04-18-00122 (April 2020)
Government Program: Medicaid

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[NEW] Indiana Paid $3.5 Million for Medicaid Non-emergency Medical Transport Claims That Did Not Comply With Federal and State Requirements

The Medicaid program pays for nonemergency medical transportation (NEMT) services that a state determines to be necessary for beneficiaries to obtain care. Prior OIG audit reports have consistently identified NEMT services as vulnerable to fraud, waste, and abuse. OIG's objective was to determine whether Indiana claimed Federal Medicaid reimbursement for NEMT service claims in accordance with federal and state requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG estimated that at least 113,086 Medicaid claims, totalling $3.5 million (federal share), did not comply with federal and state regulations. The claims for unallowable services were made because Indiana's monitoring and oversight of the Medicaid program did not ensure that providers complied with federal and state requirements for documenting and claiming NEMT services. After OIG's audit period, Indiana took additional steps to increase the oversight and monitoring of the NEMT program by contracting with a broker to administer the NEMT program.

OIG recommended that the State agency: (1) refund $3.5 million to the Federal Government, and (2) require its broker to have procedures in place to strengthen the monitoring and oversight of the NEMT program to ensure that providers document all services in accordance with federal and state requirements and maintain the correct documentation to support the services provided and provider qualifications.

Work Plan #: A-05-18-00043 (August 2020)
Government Program: Medicaid

Medicare Dialysis Services Provider Compliance Review: Bio-Medical Applications of Arecibo, Inc.

Medicare Part B covers dialysis services for beneficiaries with end-stage renal disease (ESRD). Prior OIG reviews identified inappropriate Medicare payments made for ESRD (dialysis) services that were medically unnecessary, not properly ordered, undocumented, or did not comply with Medicare consolidated billing requirements. OIG selected Bio-Medical Applications of Arecibo, Inc. (BMA), for review because it ranked among the highest-paid providers of dialysis services in Puerto Rico and Medicare surveyors identified various health and safety issues. OIG's objective was to determine whether dialysis services provided by BMA complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that BMA claimed reimbursement for dialysis services that did not comply with Medicare requirements during 96 sampled beneficiary-months. Specifically, BMA submitted claims for which (1) plans of care and/or comprehensive assessments did not meet Medicare requirements, (2) beneficiaries' height and/or weight measurements

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did not comply with Medicare requirements, (3) there were no valid physicians' orders, (4) dialysis treatments were not completed, (5) ESRD measurements were not supported and (6) home dialysis services were not documented. While BMA had internal controls to monitor and maintain complete, accurate, and accessible medical records, these controls were not always effective or followed to ensure that its claims for dialysis services complied with Medicare requirements. OIG estimated that BMA received unallowable Medicare payments of at least $96,185 for dialysis services that did not comply with Medicare requirements. Most of the errors OIG identified did not affect BMA's Medicare reimbursement for the services since they were reimbursed on a bundled per treatment basis or related to Medicare conditions for coverage. However, the deficiencies could have a significant impact on the quality of care provided to Medicare beneficiaries and could result in the provision of inappropriate or unnecessary dialysis services

OIG recommended BMA refund an estimated $96,185 to the Medicare program.

Work Plan #: A-02-17-01016 (March 2020)
Government Program: Medicare Parts A & B

Medicare Payments for Chronic Care Management

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 determined whether payments for CCM services were in accordance with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG identified 14,078 claims that resulted in $436,877 in overpayments for instances in which providers or facilities billed CCM services more than once for the same beneficiaries for the same service period. OIG identified an additional 6,087 claims that resulted in $203,575 in overpayments for instances in which the same physician billed for both CCM services and overlapping care management services for the same beneficiaries. For these 20,165 claims, beneficiaries were overcharged a total of up to $173,495 in cost sharing.

OIG recommended that CMS recoup $640,452 from providers and instruct providers to refund overcharges totaling up to $173,495 to beneficiaries; review the 37,124 outpatient claims totaling $1.2 million in potential overpayments to determine whether the outpatient facilities met the requirement to bill for CCM services and recoup any overpayments from outpatient facilities and instruct the outpatient facilities to refund corresponding overcharges to beneficiaries; and implement claim processing controls, including system edits, to prevent and detect overpayments for CCM services.

Work Plan #: A-07-17-05101 (November 2019)
Government Program: Medicare

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Medicare Incorrectly Paid Providers for Emergency Ambulance Transports from Hospitals to Skilled Nursing Facilities

A prior OIG review found that Medicare made improper and potentially improper payments of $1.9 million to providers for emergency ambulance transports to destinations other than hospitals or skilled nursing facilities (SNFs) with dates of service from calendar years (CYs) 2014 through 2016. As part of that review, OIG identified $3.2 million in payments for emergency ambulance transports from hospitals to SNFs. Because hospitals can provide emergency services, OIG conducted this separate review of emergency ambulance transports from hospitals to SNFs to determine the appropriateness of billing for them as emergency ambulance transports. OIG's objective was to determine whether Medicare payments to providers for emergency ambulance transports from hospitals to SNFs complied with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Medicare payments to providers for emergency ambulance transports from hospitals to SNFs did not comply with Federal requirements. Specifically, providers incorrectly billed all 99 sampled claim lines for emergency ambulance transports that providers indicated were from hospitals to SNFs. For these 99 claim lines, Medicare contractors made incorrect payments for 86 of them, totaling $9,563. During OIG's audit period, the Centers for Medicare & Medicaid Services (CMS) oversight was not adequate to identify incorrect billing of claim lines for emergency ambulance transports from hospitals to SNFs. If CMS had had oversight mechanisms in place, such as a fraud prevention model, it would have reduced the number of claim lines that providers incorrectly billed, and the resulting overpayments OIG identified. Based on OIG's sample results, OIG estimated that (1) providers incorrectly billed for emergency ambulance transports from hospitals to SNFs on 99 percent of the total claim lines billed and (2) Medicare made incorrect payments of $849,170. If the rate of incorrect billings in OIG sample had continued through CY 2018, the year after OIG audit period, OIG estimated that Medicare would have made an additional $119,548 in incorrect payments.

OIG recommended CMS develop a fraud prevention model specific to emergency ambulance transports from hospitals to SNFs to help ensure that payments for these ambulance transports comply with federal requirements, which could have saved an estimated $849,170 during OIG's audit period and $119,548 in CY 2018.

Work Plan #: A-09-18-03030 (September 2019)
Government Program: Medicare Parts A & B

Chiropractic Services - Part B Payments for Noncovered Services

Part B pays only for a chiropractor's manual manipulation of the spine to correct a subluxation if there is a neuro-musculoskeletal condition for which such manipulation is appropriate treatment. Prior OIG work identified inappropriate payments for chiropractic services. OIG reviewed Medicare Part B payments for chiropractic services to determine whether such payments were claimed in accordance with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that 54 services were not allowable: 42 services were medically unnecessary, 11 services were insufficiently documented, and one service was incorrectly coded. As a result, Twin Palms received $1,680 in unallowable payments.

OIG recommended Twin Palms: (1) refund to the Federal Government the portion of the estimated $317,038 overpayment for claims for chiropractic services that did not comply with Medicare requirements and are within the four-year claims reopening period and (2) establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, adequately documented in the medical records, and coded correctly.

Work Plan #: A-04-16-07065 (August 2019); A-04-16-07064 (September 2018); W-00-16-35606
Government Program: Medicare Part B