Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Provider-Focused Audits Summary

February 2020 - February 2021

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To our Compliance Colleagues and Partners:

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

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

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

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

[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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All Providers

Medicare Improperly Paid Physicians for More Than Five Spinal Facet-Joint Injection Sessions During a Rolling 12-Month Period

To address inappropriate billing for pain management tied to overuse of spinal facet-joint injections, the Medicare Administrative Contractors (MACs) developed a limitation of coverage that allows physicians to be reimbursed, during a rolling 12-month period, for a maximum of five sessions in which facet-joint injections are delivered to the lumbar region of the spine (lumbar spine) or the cervical and thoracic regions of the spine (cervical/thoracic spine). (OIG refers] to injection sessions in the two spinal areas during a rolling 12-month period as "selected facet-joint injection sessions"). However, one of the MACs' audits found that Medicare improperly paid for more than five injection sessions related to the lumbar or cervical/thoracic spines during a rolling 12-month period. OIG's objective was to determine whether Medicare paid physicians for selected facet-joint injection sessions in accordance with Federal requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG found that MACs in the 11 jurisdictions with a coverage limitation made improper payments of $748,555. During OIG's audit period, the Centers for Medicare & Medicaid Services' (CMS's) oversight was not adequate to prevent or detect these improper payments. In addition, if the remaining MAC jurisdiction had kept in place during OIG's audit period the coverage limitation, Medicare could have saved $513,328.

OIG recommended that for the 11 MAC jurisdictions with a coverage limitation for the number of facet-joint injection sessions during a rolling 12-month period, CMS: (1) direct the MACs that oversee the 11 jurisdictions to recover $748,555 in improper payments made to physicians; (2) instruct the MACs to, based upon the results of this audit, notify appropriate physicians (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the physicians can 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) develop oversight mechanisms for the MACs to implement to prevent or detect payments to physicians for more than 5 facet-joint injection sessions received by beneficiaries during a rolling 12-month period in the lumbar spine or cervical/thoracic spine; and (4) direct the MACs that oversee the 11 jurisdictions to review claims for facet-joint injections after OIG's audit period to identify instances in which Medicare paid physicians for more than 5 injection sessions received by beneficiaries during a rolling 12-month period and recover any improper payments identified.

Work Plan #: A-09-20-03003 (October 2020)
Government Program: Medicare Parts A & B

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Provider

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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Hospital

Hospitals Did Not Comply with Medicare Requirements for Reporting Cardiac Device Credits

Prior OIG audits with audit periods ranging from 2005 through 2016 found that hospitals did not always comply with Medicare requirements for reporting credits received from manufacturers for medical devices that were replaced. Specifically, hospitals did not always report to CMS device manufacturer credits that they received. One prior review estimated that services related to the replacement of seven recalled and prematurely failed cardiac medical devices cost Medicare $1.5 billion during calendar years 2005 through 2014. OIG's objective was to determine whether hospitals complied with Medicare requirements for reporting manufacturer credits associated with recalled or prematurely failed cardiac devices.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for 3,233 of the 6,558 Medicare claims, hospitals likely did not comply with Medicare requirements associated with reporting manufacturer credits for recalled or prematurely failed cardiac medical devices. Device manufacturers issued reportable credits to the hospitals for recalled or prematurely failed cardiac medical devices, but the hospitals did not adjust the claims with proper condition and value codes to reduce payments as required. As a result, 911 hospitals received payments of $76 million rather than the $43 million they should have received, resulting in $33 million in potential overpayments. Medicare contractors made these overpayments because they do not have a post payment review process that would ensure that hospitals reported manufacturer credits for cardiac medical devices.

OIG recommended that CMS: (1) instruct Medicare contractors to recover the portion of the $33 million in identified Medicare overpayments that are within the reopening period; (2) notify hospitals associated with potential overpayments outside the reopening period so that they can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule; (3) require hospitals to use condition codes 49 and 50 on claims; (4) instruct Medicare contractors to implement a post payment review process; (5) obtain device credit listings from manufacturers and determine whether providers reported credits as required; (6) direct Medicare contractors to determine whether hospitals, which OIG have identified as having billed incorrectly in both this audit and OIG's prior audit (A-05-16-00059), have engaged in a pattern of incorrect billing after OIG's audit period and, if so, take appropriate action in accordance with CMS policies and procedures; and (7) consider eliminating the current Medicare requirements for reporting device credits by reducing the payments for cardiac device replacement procedures.

Work Plan #: A-01-18-00502 (November 2020)
Government Program: Medicare Parts A & B

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Provider

CMS Did Not Ensure That Medicare Hospital Payments for Claims That Included Medical Device Credits Were Reduced in Accordance with Federal Regulations, Resulting in as Much as $35 Million in Overpayments

Medicare regulations and guidance require hospitals and ambulatory surgical centers (ASCs) to report the occurrence of credits received from manufacturers for replaced medical devices. OIG's audit focused on the risk that reported medical device credits may have been processed in a manner that resulted in Outpatient Prospective Payment System (OPPS) overpayments.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS did not ensure that OPPS payments for claims that included medical device credits were reduced in accordance with Federal regulations. These regulations require the use of the device offset amount - 100 percent of the device offset amount for each without cost or full credit replacement device and 50 percent of the device offset amount for each partial credit replacement device - when calculating the reduced OPPS payment amount. By following the Medicare Claims Processing Manual (the Manual) instructions, Medicare administrative contractors (MACs) did not comply with these regulations when calculating the claims that OIG reviewed. As a result, Medicare made estimated overpayments of as much as $35.4 million to hospitals for OIG's audit period. This error occurred because as part of Federal rulemaking in CY 2014, CMS announced its intention to update Federal regulations to reduce OPPS payments for replaced medical devices. This intended update was not finalized in the text of the Federal regulations. However, CMS revised the relevant language in its guidance Manual.

OIG recommended that CMS: (1) work with the MACs to recover from hospitals Medicare OPPS overpayments, which total as much as an estimated $35.4 million; (2) work with the MACs to recover Medicare OPPS overpayments from hospitals for any additional claims that included medical device credits and that were outside of OIG's audit period; and (3) revise the OPPS regulations or the Manual instructions to resolve the conflict between these requirements for OPPS claims with medical device credits.

Work Plan #: A-07-19-00560 (November 2020)
Government Program: Medicare Parts A & B

Medicare Hospital Provider 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.

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SunHawk Summary of OIG Audit Findings and Recommendations

St. Francis Hospital (A-05-18-00048)

OIG reported that St. Francis Hospital did not fully comply with Medicare billing requirements for 14 claims, resulting in overpayments of $204,265 for CYs 2016 and 2017. Based on OIG's sample results, OIG estimated that the St. Francis Hospital received overpayments of at least $1.6 million for the audit period.

OIG recommended that the St. Francis Hospital (1) refund to the Medicare contractor $1.6 million in estimated overpayments for the audit period for incorrectly billed claims that are within the reopening period; (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 returned overpayments as having been made in accordance with this recommendation; and (3) strengthen its controls to ensure full compliance with Medicare requirements; specifically ensure that all IRF beneficiaries meet Medicare criteria for acute inpatient rehabilitation, all inpatient beneficiaries meet Medicare requirements for inpatient hospital services, procedure and diagnosis codes are supported in the medical records and staff are properly trained, and medical records accurately document distinct procedural services and staff are properly trained.

Alta Bates Summit Medical Center (A-04-19-08071)

OIG found that Alta Bates Summit Medical Center did not fully comply with Medicare billing requirements for 46 claims, resulting in overpayments of $1.6 million for the audit period. Specifically, 45 inpatient claims and 1 outpatient claim had billing errors. Based on OIG's sample results, OIG estimated that the hospital received overpayments of approximately $16.4 million for the audit period. During OIG's audit, the hospital submitted four of these claims for reprocessing, and OIG verified those claims as correctly reprocessed. Accordingly, OIG has reduced the recommended refund by $49,118.

OIG recommended that Alta Bates Summit Medical Center refund to the Medicare contractor $16.3 million ($16.4 million less $49,118 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.

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.

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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:

- Twenty-seven 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

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$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.

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-05-18-00048 (October 2020); A-04-19-08071; (September 2020); 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

Cedars-Sinai Medical Centre: Audit of Medicare Payments for Bariatric Surgeries

Medicare paid hospitals $372 million for bariatric surgeries provided to Medicare beneficiaries in calendar years 2015 and 2016. Bariatric surgery helps those with morbid obesity to lose weight by making changes to their digestive system. Although OIG has not conducted an audit in this area, the Centers for Medicare & Medicaid Services' (CMS's) study of certain bariatric surgery procedure codes found that 98 percent of improper payments lacked sufficient documentation to support the procedures. After analyzing Medicare claim data for bariatric surgery claims with dates of service from January 2015 through December 2016 (audit period), OIG selected for audit Cedars-Sinai Medical Center (Cedars-Sinai), located in Los Angeles, California. OIG's objective was to determine whether Cedars-Sinai complied with Medicare requirements and the Medicare contractor's local coverage determinations (LCDs) and local coverage article (LCA) when billing for bariatric surgeries.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for 25 claims, Cedars-Sinai did not comply with Noridian's specifications. Specifically, Cedars-Sinai did not provide adequate documentation of the beneficiaries' multidisciplinary medical evaluations or participation in a weight management program. Cedars-Sinai did not comply with the specifications in the LCDs for 12 claims, with payments totalling $154,074, and did not comply with the specifications in the LCA for 13 claims, with payments totalling $175,199. As of the publication of this report, these payments include claims outside of the 4-year reopening period.

OIG recommended that Cedars-Sinai: (1) refund to Medicare the portion of the $154,074 in overpayments for bariatric surgery claims that did not comply with the specifications in the LCDs and that are within the 4-year reopening period; (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; (3) work with Noridian to take action deemed necessary by CMS or Noridian, or both, regarding $175,199 in payments for bariatric surgery claims with dates of service on or after the effective date of the LCA; (4) update its patient checklist to include all of Noridian's specifications for billing bariatric surgeries; and (5) obtain supporting medical record documentation from other providers, such as primary care physicians, mental health providers, or dietitians, before performing any future bariatric surgeries.

Work Plan #: A-09-18-03010 (October 2020)
Government Program: Medicare Parts A & B

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Medicare Critical Care Services Provider Compliance Audit: Clinical Practices of the University of Pennsylvania

Medicare paid approximately $1.6 billion for critical care services provided to Medicare beneficiaries nationwide from October 2016 through March 2018 (audit period). A previous OIG review of critical care services found that few problems existed and concluded that those problems could be corrected by Medicare contractors. However, that review did not utilize medical review to determine whether the critical care services were appropriate and medically necessary. OIG selected for audit Clinical Practices of the University of Pennsylvania (Clinical Practices) because it was one of the 10 highest-paid providers of critical care services during OIG's audit period. OIG's objective was to determine whether Clinical Practices complied with Medicare requirements when billing for critical care services performed by its physicians.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Clinical Practices did not comply with Medicare billing requirements for 14 critical care services, and these errors resulted in Clinical Practices receiving $1,399 in unallowable Medicare payments. These errors occurred because Clinical Practices incorrectly identified and billed critical care services for physician services that did not meet Medicare requirements. Based on OIG's sample results, OIG estimated that Clinical Practices received overpayments of at least $151,588 for the audit period.

OIG recommended that Clinical Practices: (1) refund to the Medicare administrative contractor $151,588 in estimated overpayments for critical care services; (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) strengthen policies and procedures to ensure that critical care services billed to Medicare are adequately documented and correctly billed.

Work Plan #: A-03-18-00003 (October 2020)
Government Program: Medicare Parts A & B

Baylor Scott & White—College Station: Audit of Outpatient Outlier Payments

Medicare makes supplemental payments to hospitals, known as outlier payments, which are designed to protect hospitals from significant financial losses resulting from patient-care cases that are extraordinarily costly. Unlike predetermined payment amounts for most Medicare hospital claims, outlier payments are directly influenced by hospital charges. OIG selected Baylor Scott & White-College Station (College Station) based on outpatient outlier payments increasing from $82,555 in 2015 to $2.6 million in 2016. OIG's objective was to determine whether outpatient outlier payments received by College Station were based on properly billed claims.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that College Station did not properly bill the claims related to 82 outlier payments which resulted in improper outlier payments during OIG's audit period. These 82 claims, which had outliers totaling $474,282, contained 174 billing errors. The billing errors primarily occurred because College Station did not have adequate controls to prevent errors related to overcharged observation time, charge errors, and coding errors.

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OIG recommended that College Station refund to the Medicare contractor $189,276 in estimated overpayments for incorrectly billed claims that are within the reopening period. OIG also recommended that College Station improve procedures, provide education and implement changes to their billing system to ensure claims billed to Medicare are accurate.

Work Plan #: A-06-18-04003 (September 2020)
Government Program: Medicare Parts A & B

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

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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 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

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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 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

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.

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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; 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.

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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

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 Centres 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

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States 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 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

Illinois (A-05-18-00037)

OIG reported that Illinois 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 site visits, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 15 nursing homes that OIG reviewed. Specifically, OIG found 53 instances of noncompliance with life safety requirements and 184 instances of noncompliance with emergency preparedness requirements. As a result, residents at the 15 nursing homes were at increased risk of injury or death during a fire or other emergency.

The identified deficiencies occurred because the existing life safety training program for nursing home management could not educate all Illinois nursing home management in a timely manner, and the State did not offer an emergency preparedness training program for nursing home management. (Currently, CMS requires neither of the two training programs.) Further, Illinois performed abbreviated surveys of emergency preparedness plans and had insufficient personnel for its workload. In addition, Illinois did not determine whether carbon monoxide alarms were installed in accordance with State law.

OIG recommended that Illinois; (1) follow up with the 15 nursing homes to verify that corrective actions have been taken regarding the deficiencies that OIG identified, (2) conduct more thorough emergency preparedness reviews for the safety and protection of nursing home residents and staff, (3) work with CMS to develop emergency preparedness training and expand life safety training sessions to accommodate all nursing home management, (4) consider increasing staffing levels to address caseload thresholds for State surveyors, and (5) consider modifying its survey procedures to check for carbon monoxide alarms required by Illinois law.

North Carolina (A-04-19-08070)

OIG reported that, of the 20 North Carolina nursing homes that OIG visited, 18 had deficiencies in areas related to life safety or emergency preparedness. Specifically, 18 nursing homes had 64 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 power cords. Furthermore, 14 nursing homes had 124 instances of noncompliance with emergency preparedness requirements related to written emergency plans, emergency power, plans for sheltering in place and tracking residents and staff during and after an emergency, emergency communications plans, and emergency plan training and testing.

The instances of noncompliance occurred because nursing homes had inadequate management oversight and high staff turnover. In addition, North Carolina 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 8 to 15 months, even at these higher risk nursing homes.

OIG recommended that North Carolina; (1) follow up with the 18 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.

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

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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 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, 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-04-19-08070; (September 2020) A-05-18-00037 (September 2020); 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

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States Continued To Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018

The nursing home complaint process is a critical safeguard to protect the vulnerable residents of nursing homes. CMS relies on the States' respective survey agencies to serve as the front-line responders to address health and safety concerns raised by residents, their families, and nursing home staff. State survey agencies (hereinafter, States) must conduct onsite investigations within certain timeframes for the two most serious levels of complaints-those that allege serious injury or harm to a nursing home resident and require a rapid response to address the complaint and ensure residents' safety. A previous OIG report found that a few States fell short in the timely investigation of the most serious nursing home complaints between 2011 and 2015. To follow-up on this report, OIG examined the extent to which States met required timeframes for investigating the most serious nursing home complaints from 2016 through 2018.

SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported that the rate of nursing home complaints per 1,000 nursing home residents increased from 45 in 2015 to 52 in 2018. Twenty-one States failed to meet CMS's timeliness threshold for the second-most serious level of complaints in all three years from 2016 through 2018, and ten of these States did not meet the threshold for eight consecutive years, from 2011 through 2018. Of the five States that fell short in timely investigation of the most serious nursing home complaints from 2011 through 2015, Georgia had limited improvement, while Arizona, Maryland, New York, and Tennessee continued to fall short through 2018. Furthermore, OIG found that from 2016 through 2018, trends in late investigations of complaints in New Jersey, Illinois, and Texas raise concerns.

OIG reported that the analysis raises questions about some States' ability to address serious nursing home complaints and also about the effectiveness of CMS's oversight of States. OIG found that many States are consistently failing to meet required timeframes for investigating the most serious nursing home complaints. States that OIG communicated with face challenges with receiving a high volume of complaints, triaging complaints, and having adequate human resources to investigate complaints. CMS has worked with States to address these challenges, yet few States have made progress. To ensure that States conduct timely investigations, OIG recommended that CMS should ensure that all States receive training on the triage guidance it plans to update. Furthermore, CMS should also identify new approaches to address States that are consistently failing to meet required timeframes for investigating the most serious nursing home complaints.

Work Plan #: OEI-01-19-00421 (September 2020)
Government Program: Medicare Parts A & B

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 OIG 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.

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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

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.

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SunHawk Summary of OIG Evaluation Findings and Recommendations

OIG reported 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

State Compliance with Requirements for Reporting and Monitoring Critical Incidents

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

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that North Carolina did not ensure that nursing facilities always reported potential abuse or neglect of Medicaid beneficiaries transferred from nursing facilities to hospital emergency departments. In addition, it did not always fully comply with Federal requirements for assigning a priority level to reported allegations of potential abuse and neglect or for correctly recording the associated dates. Finally, North Carolina's complaint and incident report program may not have been effective in promoting and protecting the health, safety, and welfare of residents, patients, and other clients receiving health care services.

OIG recommended that North Carolina continue working with the Centers for Medicare & Medicaid Services (CMS) to provide clear guidance to nursing facilities regarding what constitutes a reportable incident and when to report and revise its policies and procedures to require that it: (1) assign a priority level to incident reports even if the nursing facilities' investigations are not complete, (2) enter into CMS's automated tracking system the date that North Carolina first receives incident reports, and (3) manage employee absences to better prevent them from interfering with assigning priority levels

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to allegations within appropriate timeframes. OIG also made procedural recommendations, including recommendations to address OIG's concerns with the effectiveness of North Carolina's complaint and incident report program.

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

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.

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

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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] Southeastern Home Health (A-03-17-00004)

OIG reported that Southeastern did not comply with Medicare billing requirements for 18 of the 100 home health claims that OIG reviewed. For these claims, Southeastern received overpayments of $46,404 for services provided in calendar years 2015 and 2016. Specifically, Southeastern incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, and (3) claims that were assigned with incorrect Health Insurance Prospective Payment System (HIPPS) codes. On the basis of OIG's sample results, OIG estimated that Southeastern received overpayments of at least $1.8 million for OIG's audit period. All 100 claims within OIG sample are outside of the Medicare 4-year claim-reopening period.

OIG recommended that Southeastern exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommend that Southeastern 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) the correct HIPPS payment codes are billed.

Total Patient Care Home Health (A-06-16-05005)

OIG reported that TPC did not comply with Medicare billing requirements for 32 of the 100 home health claims that OIG reviewed. For these claims, TPC received overpayments of $75,461 for services provided during OIG's audit period, October 1, 2014, through September 30, 2016. Specifically, TPC incorrectly billed Medicare for services provided to beneficiaries who were not homebound or did not require skilled services. On the basis of OIG's sample results, OIG estimated that TPC received overpayments of at least $1.7 million for OIG's audit period.

OIG recommended that TPC exercise reasonable diligence to identify, report and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommended that TPC 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.

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The Palace at Home (A-04-17-07067)

OIG reported that the Palace did not comply with Medicare billing requirements for 20 of the 100 home health claims that OIG audited. For these claims, The Palace received overpayments of $30,387 for services provided during OIG's audit period. Specifically, The Palace incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound; (2) services provided to beneficiaries who did not require skilled services; and (3) claims that it assigned with incorrect Health Insurance Prospective Payment System codes. These errors occurred primarily because The Palace did not have adequate controls to prevent the incorrect billing of Medicare claims. Based on OIG's sample results, OIG estimated that The Palace received overpayments of at least $731,304 for OIG's audit period. All the incorrectly billed claims are outside of the four-year reopening period.

OIG recommended that The Palace exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. OIG also recommend that The Palace strengthen its procedures to ensure full compliance with requirements for billing home health services.

VNA of Central Jersey (A-02-17-01025)

OIG reported that VNA of Central Jersey did not comply with Medicare billing requirements for 14 of the 100 home health claims that OIG reviewed. For these claims, VNA of Central Jersey received overpayments of $21,553 for services provided during OIG audit period. Specifically, VNA of Central Jersey incorrectly billed Medicare for services provided to beneficiaries who were not homebound or did not require skilled services. It also inappropriately received reimbursement for claims for some services that were not provided, not reasonable or necessary, and incorrectly billed. Based on OIG's sample results, OIG estimated that VNA of Central Jersey received overpayments of at least $2 million for the audit period.

OIG made several recommendations to VNA of Central Jersey, including that it: (1) refund to the Medicare program the portion of the estimated $2 million overpayment 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; (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of OIG audit period; and (4) strengthen its procedures for billing home health services.

Gem City Home Care (A-05-18-00011)

OIG reported that Gem City received overpayments of $40,621 for services provided in fiscal years (FYs) 2016 and 2017. Specifically, Gem City incorrectly billed Medicare for services provided to beneficiaries who; (1) were not homebound, or (2) did not require skilled services. Based on OIG's sample results, OIG estimated that Gem City received overpayments of at least $2.67 million during this period.

OIG made several recommendations to Gem City, including that it: (1) refund to the Medicare program the portion of the estimated $2.67 million in overpayments for incorrectly billed claims that are within the 4-year reopening period; (2) for the remaining portion of the estimated $2.67 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 audit period; and (4) strengthen its procedures to ensure that the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific

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factors qualifying beneficiaries as homebound are documented, and beneficiaries are receiving only reasonable and necessary skilled services.

Mercy Health Visiting Nurse Services (A-05-18-00035)

OIG reported that Mercy did not comply with Medicare billing requirements for 23 of the 100 home health claims that OIG reviewed. For these claims, Mercy received overpayments of $42,466 for services provided in calendar years (CYs) 2016 and 2017. Specifically, Mercy incorrectly billed Medicare for; (1) services provided to beneficiaries who were not homebound, or (2) services provided to beneficiaries who did not require skilled services. Based on OIG's sample results, OIG estimated that Mercy received overpayments of approximately $1.1 million for CYs 2016 and 2017.

OIG made several recommendations to Mercy, including that it: (1) refund to the Medicare program the portion of the estimated $1.1 million 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's audit period.

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.

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-03-17-00004 (January 2021); A-06-16-05005 (December 2020); A-04-17-07067 (November 2020); A-02-17-01025 (October 2020); A-05-18-00011 (October 2020); A-05-18-00035 (September 2020); 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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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 reported 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

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Hospice

Medicare Hospice Provider Compliance Audit: Hospice Compassus, Inc., of Payson, Arizona

The Medicare hospice benefit allows providers to claim Medicare reimbursement for hospice services provided to individuals with a life expectancy of six months or less and who have elected hospice care. Previous OIG reviews found that Medicare inappropriately paid for hospice services that did not meet Medicare requirements. OIG's objective was to determine whether hospice services provided by Hospice Compassus, Inc., of Payson, Arizona (Payson), complied with Medicare requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that Compassus did not comply with Medicare requirements for 39 of the 100 claims in OIG sample. For these claims, Compassus claimed Medicare reimbursement for hospice services: (1) for which the associated beneficiary did not meet eligibility requirements; (2) that were not documented; and (3) at a reimbursement rate associated with a level of care higher than what the associated beneficiary required. These improper payments occurred because Compassus's policies and procedures for ensuring that claims for hospice service met Medicare requirements were not always effective. Based on OIG's sample results, OIG estimated that Compassus received at least $1.8 million in Medicare reimbursement for hospice services that did not comply with Medicare requirements.

OIG recommended that Compassus exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule, and based on the results of OIG's audit, identify, report, and return any additional overpayments as having been made in accordance with OIG's recommendations. OIG also recommended that Compassus strengthen its procedures to ensure that hospice services comply with Medicare requirements.

Work Plan #: A-02-16-01023 (November 2020)
Government Program: Medicare Parts A & B

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)

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OIG's reported that 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

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.

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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

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Medical Equipment & Supplies

Medicare-Allowed Charges for Non-invasive Ventilators Are Substantially Higher Than Payment Rates of Select Non-Medicare Payers

Medicare-allowed charges for noninvasive ventilators increased from $279.9 million in 2016 to $424.4 million in 2018, an increase of 52 percent. OIG is concerned about the relationship of these increased costs to prices per noninvasive ventilator, and specifically concerned about whether Medicare-allowed charges are comparable with payment rates of select non-Medicare payers. OIG's objective was to determine whether Medicare-allowed charges for noninvasive ventilators were comparable with payment rates of select non-Medicare payers.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that for CYs 2016 through 2018, OIG estimated that Medicare and beneficiaries could have saved $86.6 million if Medicare-allowed charges were comparable with payment rates of select non-Medicare payers on HCPCS code E0466. Of this payment difference, OIG estimated that Medicare paid $69.3 million and Medicare beneficiaries paid $17.3 million. Generally, Medicare-allowed charges are higher than select non-Medicare payer payment rates because the Centers for Medicare & Medicaid Services (CMS) does not routinely evaluate pricing trends for noninvasive ventilators or payment rates of select non-Medicare payers. Rather, CMS uses statutorily mandated fee schedule payments that have an economic update factor applied to them annually. In 2016, CMS was required to adjust certain fee schedule amounts for durable medical equipment, prosthetics, orthotics, and supplies using information from the competitive bidding program. But this change did not affect the noninvasive ventilator HCPCS code reviewed for this report.

OIG recommended that CMS review Medicare-allowed charges for noninvasive ventilators HCPCS code E0466, for which Medicare and beneficiaries could have potentially saved an estimated $86.6 million in CYs 2016 through 2018, and add noninvasive ventilators HCPCS code E0466 to the competitive bidding program as soon as practicable.

Work Plan #: A-05-20-00008 (September 2020)
Government Program: Medicare Parts A & B

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.

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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.

SunHawk Summary of OIG Audit Findings and Recommendations

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.

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

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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

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Accountable Care Organizations (ACOs)

CMS's Monitoring Activities for Ensuring That Medicare Accountable Care Organizations Report Complete and Accurate Data on Quality Measures Were Generally Effective, but There Were Weaknesses That Could Be Improved

Accountable Care Organizations (ACOs) in the Medicare Shared Savings Program (MSSP) may be eligible to receive shared savings payments from the Centers for Medicare & Medicaid Services (CMS) if the ACOs reduce health care costs and satisfy the MSSP 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) 2017, ACOs were required to report data on 31 quality measures through 3 methods of submission: a patient survey, claims and administrative data, and the designated CMS web portal. If ACOs do not report complete and accurate data, shared savings payments could be affected. Previous OIG audits of two selected ACOs assessed whether they reported complete and accurate data on selected quality measures. OIG's objective was to determine whether CMS's monitoring activities were effective for ensuring that ACOs report complete and accurate data on quality measures.

SunHawk Summary of OIG Audit Findings and Recommendations

OIG reported that CMS's monitoring activities were generally effective for ensuring that ACOs report complete and accurate data on quality measures through claims and administrative data and the CMS web portal. (For example, ACOs report data through the web portal on whether beneficiaries received preventive care, such as depression screenings.) However, OIG identified weaknesses in CMS's monitoring activities that could lead to ACOs reporting incomplete or inaccurate data through the patient survey. Specifically, CMS did not ensure that its contractor; (1) verified survey vendors' correction of identified issues even though the issues were directly related to the collection or reporting of data, and (2) provided feedback reports in time for survey vendors to include in their Quality Assurance Plans (QAPs) all of the changes implemented to address identified issues. (A QAP describes a survey vendor's process for performing the patient survey and complying with the CMS Quality Assurance Guidelines.) In addition, CMS did not ensure that its contractor reviewed survey instruments (e.g., mail survey packages) translated into other languages. As a result of these weaknesses, ACOs may not report complete and accurate data on quality measures, which could affect the ACOs' overall quality performance scores and ultimately the shared savings payments.

OIG recommended to improve its monitoring activities for ensuring that ACOs report complete and accurate data on quality measures, that CMS update the Statement of Work to require its contractor to; (1) verify that survey vendors have corrected identified issues that directly relate to the collection or reporting of data, (2) confirm that all implemented changes to address the identified issues are included in QAPs before they are approved, and (3) review the translated survey templates, mail survey packages, and telephone survey scripts to ensure that they are consistent with the English versions.

Work Plan #: A-09-18-03033 (September 2020)
Government Program: Medicare Parts A & B

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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 reported 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 reported 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

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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

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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 reported 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 reported 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 reported 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 reported 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.

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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

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Laboratory

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.

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Provider

SunHawk Summary of OIG Audit Findings and Recommendations

Novitas (A-06-17-04002)

OIG reported 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 reported 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

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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

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 reported 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.

Provider

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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Other Providers and Suppliers

States Claimed Medicaid Reimbursement for Services 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 States claimed Federal Medicaid reimbursement for NEMT service claims in accordance with federal and state requirements.

SunHawk Summary of OIG Audit Findings and Recommendations

[NEW] Massachusetts (A-01-19-00004)

OIG reported that Massachusetts claimed Federal Medicaid reimbursement for 86 of 100 sampled lines of service submitted by transportation providers that did not comply with certain Federal and State requirements. The improper claims for unallowable services were made because the State's monitoring and oversight of the NEMT program did not ensure that NEMT services were for qualifying medical services and were adequately documented. In addition, for all 100 sample items, driver qualifications and vehicle inspection, registration, and maintenance policies or schedules were not adequately documented.

OIG recommended that Massachusetts: (1) refund $7,071,365 million to the Federal Government, (2) perform data matches to all claims billed on the day of an NEMT service to ensure only NEMT claims are paid when there is a corresponding qualifying medical service, (3) work with its brokers to ensure that documentation contains all necessary elements to support the NEMT service, (4) evaluate opportunities to better monitor transportation services, and (5) work with its brokers to implement controls that ensure drivers and vehicles used to provide NEMT services can be directly and clearly traced to the correct driver qualifications and vehicle records.

Indiana (A-05-18-00043)

OIG reported that at least 113,086 Medicaid claims, totaling $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-01-19-00004 (January 2021); A-05-18-00043 (August 2020)
Government Program: Medicaid

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Provider

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 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

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