Healthcare Audit and Enforcement Risk Analysis

HHS OIG Completed Provider-Focused Audits Summary

JANUARY 2019 - JUNE 2020

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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 focused insights into the over 400 audits, performed by HHS OIG, over the last 18 months, SunHawk Consulting, LLC, has gathered, organized, and summarized this audit activity for the Payer, Provider, and Life Science Industries.

HHS OIG Office of Audit Services and Office of Evaluation and Inspections issues approximately 300 audits and evaluations a year. The findings and recommendations provided herein are extracted from the specific audits included in this report and referenced by their respective report numbers at the end of each abstract. SunHawk's report summarizes completed audits and evaluations over the last 18 months and sorts relevant audits into Provider, Payer and Life Sciences categories. The electronic version of this report includes hyperlinks to the original audits. SunHawk's individual summaries of OIG's completed audits do not include the Auditee's comments which are typically included as an Appendix to the relevant audit report.

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

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

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Intensity-Modulated Radiation Therapy

Intensity-modulated radiation therapy (IMRT) is an advanced mode of high-precision radiotherapy that uses computer-controlled linear accelerators to deliver precise radiation doses to a malignant tumor or specific areas within the tumor. IMRT is provided in two treatment phases: planning and delivery. Certain services should not be billed when they are performed as part of developing an IMRT plan. Prior OIG reviews identified hospitals that incorrectly billed for IMRT services. OIG reviewed Medicare outpatient payments for IMRT to determine whether the payments were made in accordance with Federal requirements.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that National Government Services, Inc. (NGS) incorrectly paid hospitals for IMRT services provided to nearly all the beneficiaries associated with OIG review. The overpayments occurred because (1) NGS' claim processing system did not adequately prevent payments to hospitals for all incorrectly billed IMRT services and (2) hospitals were unfamiliar with or misinterpreted Medicare guidance when billing for certain IMRT services, or cited clerical errors.

OIG made three recommendations to NGS to recover the overpayments identified in OIG report. OIG also made two procedural recommendations to implement payment edits and to educate hospitals on properly billing for IMRT services.

Work Plan #: A-02-16-01007; A-02-16-01006; W-00-16-35733
Government Program: Medicare Parts A & B

Duplicate Graduate Medical Education Payments

Medicare pays teaching hospitals for direct graduate medical education (DGME) and indirect medical education (IME) costs. When payments for DGME and IME costs are being calculated, no intern or resident may be counted by Medicare as more than one full-time equivalent (FTE) employee (42 CFR §§ 413.78(b) and 412.105(f)(1)(iii)). To ensure that this incorrect counting does not occur, Centers for Medicare & Medicaid Services created the Intern and Resident Information System (IRIS). Prior OIG reviews determined that hospitals received duplicate reimbursement for Graduate Medical Education (GME) costs. OIG will review provider data from IRIS to determine whether hospitals received duplicate or excessive GME payments. OIG also assessed the effectiveness of IRIS in preventing duplicate payments for GME costs. If duplicate payments were claimed, OIG determined which payment was appropriate.

SunHawk Summary of OIG Findings and Recommendations

OIG reported CMS generally ensured that hospitals in selected MAC jurisdictions claimed Medicare GME reimbursement in accordance with Federal requirements. However, in seven of eight audits, OIG identified some instances in which teaching hospitals did not always comply with Federal requirements when claiming Medicare GME reimbursement for residents. Specifically, OIG found that hospitals in the six MAC jurisdictions OIG reviewed claimed GME reimbursement

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for residents who were claimed by more than one hospital for the same period and whose total FTE count exceeded one, totaling almost $4 million in excess Medicare GME reimbursement.

OIG recommended CMS take steps to ensure that no resident is counted as more than one FTE. This could include implementing policies and procedures to analyze resident data or requiring MACs to determine if residents claimed by hospitals in their jurisdiction were claimed as more than one FTE. Because OIG audits covered only six MAC jurisdictions across various fiscal periods, OIG believes that, if CMS took steps to ensure that all MAC jurisdictions implemented procedures, it could achieve significant cost savings.

Work Plan #: A-02-17-01017; W-00-15-35432; W-00-17-35432
Government Program: Medicare Parts A & B

Health-Care-Acquired Conditions - Medicaid Managed Care Organizations

Previous OIG reviews found that some States continued to make Fee-for-Service Medicaid payments for hospital care associated with health-care-acquired conditions and provider preventable conditions. Provider preventable conditions (PPCs), are certain reasonably preventable conditions caused by medical accidents or errors in the health care setting. The ACA, § 2702, and implementing regulations at 42 CFR, § 447.26, prohibit Federal payments for provider preventable conditions. Because OIG found problems with States making fee-for-service payments associated with provider preventable conditions, OIG is expanding to manage care arrangements. OIG determined whether Medicaid Managed Care Organizations (MCO's)s have continued to make payments to providers for inpatient hospital services related to treating certain provider preventable conditions.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that MCOs paid providers approximately $4 million for 241 claims that contained PPCs. Rhode Island's internal controls were not adequate to ensure that its MCOs complied with Federal and State requirements. For instance, Rhode Island did not follow up with the MCOs to determine why present on admission codes were missing or whether the payments made for the related claims complied with Federal and State requirements. In addition, the MCOs did not have policies or procedures to identify PPCs on claims for inpatient hospital services or determine whether payments for claims containing PPCs should have been reduced. As a result, the unallowable portion of the $4 million identified for OIG audit period was included in the capitation payment rates for State fiscal years 2017 and 2018.

OIG recommended Rhode Island (1) work with the MCOs to determine the portion of the $4 million that was unallowable for claims containing PPCs and its impact on current and future capitation payment rates; (2) include a clause in its managed-care contracts with the MCOs that would allow the State agency to recoup funds from the MCOs when contract provisions and Federal and State requirements are not met, thereby resulting in potential cost savings; and (3) require the MCOs to implement internal controls to prohibit payments for inpatient hospital services related to treating PPCs, and other procedural recommendations.

Work Plan #: A-01-17-00004; W-00-17-31519
Government Program: Medicaid

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

This audit is part of a series of hospital compliance audits. Using computer matching, data mining, and data analysis techniques, OIG identified hospital claims that were at risk for noncompliance with Medicare billing requirements. For calendar year 2017, Medicare paid hospitals $206 billion, which represents 55 percent of all fee-for-service payments for the year. OIG's objective was to determine whether The Ohio State University Hospital (the Hospital) complied with Medicare requirements for billing inpatient and outpatient services on selected types of claims.

SunHawk Summary of OIG Findings and Recommendations

Ohio State Hospital

OIG reported the Hospital complied with Medicare billing requirements for 98 of the 145 inpatient and outpatient claims OIG audited. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 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. On the basis of OIG sample results, OIG estimated that the Hospital received overpayments of at least $3.7 million for the audit period.

OIG recommended the Hospital refund to the Medicare contractor $3.7 million in estimated overpayments for incorrectly billed services that are within the 4-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. The detailed recommendations are included in the body of the report.

Texas Health Presbyterian Hospital

OIG reported the Hospital complied with Medicare billing requirements for 59 of the 100 inpatient and outpatient claims OIG reviewed. However, the Hospital did not fully comply with Medicare billing requirements for the remaining 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 1 outpatient claim had a billing error, resulting in an overpayment of $91. Specifically, the Hospital incorrectly billed: • 27 inpatient rehabilitation claims that either did not meet coverage or documentation requirements, • 8 inpatient Medicare Part A claims that should have been billed as outpatient or outpatient with observation, and • 1 outpatient and 5 inpatient claims that were incorrectly coded. On the basis of OIG sample results, OIG estimated that the Hospital received overpayments of at least $10.7 million for the audit period. During the course of OIG audit, the 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 the 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 audit period, in accordance with the 60-day rule; and strengthen controls to ensure full compliance with Medicare requirements.

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Northwest Medical Center

OIG reported the Hospital complied with Medicare billing requirements for 80 of the 100 inpatient and outpatient claims OIG reviewed. However, it did not fully comply with Medicare billing requirements for the remaining 20 claims, resulting in overpayments of $201,624 for the audit period. The 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, the Hospital 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 7 outpatient claims that were incorrectly coded. On the basis of OIG sample results, OIG estimated that the Hospital received overpayments of at least $1.2 million for the audit period. During the course of OIG audit, the Hospital 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.

Work Plan #: A-05-18-00042; A-04-18-08068; A-04-18-08064
Government Program: Medicare Parts A & B

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

Medicare makes the full Medicare Severity Diagnosis-Related Group (MS-DRG) payment to a hospital that discharges an inpatient beneficiary "to home." Under the post-acute-care transfer policy, however, for certain qualifying MS-DRGs, Medicare pays a hospital that transfers an inpatient beneficiary to post-acute care a per diem rate for each day of the stay, not to exceed the full MS-DRG payment that would have been made if the inpatient beneficiary had been discharged to home. A prior OIG review identified Medicare overpayments to hospitals that did not comply with Medicare's post-acute-care transfer policy (42 CFR § 412.4(c)). OIG found that hospitals transferred patients to certain post-acute-care settings but improperly claimed the higher reimbursement associated with discharges "to home." Specifically, these hospitals used incorrect patient discharge status codes on their claims by indicating that their patients were discharged "to home" rather than transferred to a post-acute-care setting (e.g., home health services, skilled nursing facilities (SNFs), non-Inpatient Prospective Payment System (IPPS) hospitals or hospital units). OIG's review found that CMS common working file (CWF) edits related to transfers to home health care, SNFs, and non-IPPS hospitals were not working properly. As a result, OIG recommended that CMS correct the CWF edits, ensure they are working properly, and recover the identified overpayments in accordance with its policies and procedures. CMS agreed with the recommendations and stated that it will update the CWF edits. This follow-up audit determined whether CMS corrected the CWF edits and ensured they are working properly.

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SunHawk Summary of OIG Findings and Recommendations

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

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

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

Reconciliations of Outlier Payments

Outliers are additional payments that Medicare provides to hospitals for beneficiaries who incur unusually high costs. The original outlier payments are based on the cost-to-charge ratio from the most recently settled cost report. The actual cost-to-charge ratio for the year in which the service was provided is available only at the time of cost report settlement for that year. Centers for Medicare & Medicaid Services performs outlier reconciliations at the time of cost report settlement. Without timely reconciliations and final settlements, the cost reports remain open and funds may not be properly returned to the Medicare Trust Fund (42 CFR § 412.84(i)(4)). OIG reviewed Medicare outlier payments to hospitals determining whether Centers for Medicare & Medicaid Services performed necessary reconciliations in a timely manner to enable Medicare contractors to perform final settlement of the hospitals' associated cost reports. OIG determined whether the Medicare contractors referred all hospitals that meet the criteria for outlier reconciliations to Centers for Medicare & Medicaid Services.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that from fiscal years 2011 through 2014, CMS paid the 60 hospitals a net of $502 million more in outlier payments than the hospitals would have been paid if their outlier payments had been timely reconciled. (OIG refers to this net amount as excessive outlier payments.) Specifically, CMS paid 53 hospitals $541 million more than they would have been paid and 7 hospitals $39 million less than they would have been paid over the 4-year period. CMS did not detect or recover these excessive outlier payments because the 236 associated cost reports did not meet the 10-percentagepoint threshold for reconciliation.

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

Work Plan #: A-05-16-00060; W-00-16-35451; W-00-16-35781

Government Program: Medicare Parts A & B

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 with regard to how hospitals report deferred compensation costs. OIG reviewed hospital controls over the reporting of wage data used to calculate wage indexes for Medicare payments (SSA §§ 1886(d)(3) and 1886(d)(3)(E)).

SunHawk Summary of OIG Findings and Recommendations

OIG reported that:

1. The 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, the Hospital overstated its wages and wage-related costs.

2. OIG identified these significant vulnerabilities in the wage index system: (1) absent misrepresentation or falsification, CMS lacks the authority to penalize hospitals that submit inaccurate or incomplete wage data; (2) MAC limited reviews do not always identify inaccurate wage data; (3) the rural floor decreases wage index accuracy; and (4) hold-harmless provisions in Federal law and CMS policy pertaining to geographically reclassified hospitals' wage data decrease wage index accuracy.

OIG recommended that:

1. The Hospital should (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 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.

2. The Hospital should 2) strengthen review and reconciliation procedures to ensure that the Medicare wage data it reports to CMS in the future are accurate, allowable, supportable, and in compliance with Medicare requirements.

3. (1) CMS and the Secretary of Health and Human Services revisit the possibility of comprehensive reform, including the option of a commuting-based wage index. In the absence of movement toward comprehensive reform, OIG recommended that (2) CMS seek legislative authority to penalize hospitals that submit inaccurate or incomplete wage data in the absence of misrepresentation or falsification; (3) seek legislation to repeal the law creating the rural floor; and (4) seek legislation to repeal the hold harmless provisions in Federal law, allowing CMS to calculate each area wage index based on the wage data of hospitals that reclassify into the area and hospitals geographically located in the area provided that they do not reclassify out. Additionally, OIG recommended that (5) CMS rescind its hold harmless policy relating to geographically reclassified hospitals' wage data and (6) work with the MACs to develop a program of in-depth wage data audits at a limited number of

hospitals each year, focusing on hospitals whose wage data have high levels of influence on the wage index of their area.

Work Plan #: A-01-17-00509; A-01-17-00510; A-01-17-00500; W-00-16-35452; W-00-17-35725
Government Program: Medicare Parts A & B

Hyperbaric Oxygen Therapy (HBO) Services - Provider Reimbursement in Compliance with Federal Regulations

Hyperbaric oxygen (HBO) therapy involves giving a beneficiary high concentrations of oxygen within a pressurized chamber in which the beneficiary intermittently breathes 100 percent oxygen. HBO therapy is primarily an adjunctive treatment for the management of select nonhealing wounds. In accordance with Centers for Medicare & Medicaid Services Publication 100-03, National Coverage Determinations Manual, Ch. 20, § 20.29(A), a beneficiary must meet 1 of 15 covered conditions for providers to receive HBO reimbursement. Prior OIG reviews expressed concerns that: (1) beneficiaries received treatments for noncovered conditions, (2) medical documentation did not adequately support HBO treatments, and (3) beneficiaries received more treatments than were considered medically necessary. OIG determined whether Medicare payments related to HBO outpatient claims were reimbursed in accordance with Federal requirements.

SunHawk Summary of OIG Findings and Recommendations

OIG reported First Coast paid 48 providers for HBO therapy services that did not comply with Medicare requirements. Of the 120 sampled outpatient claims totaling $415,513, First Coast made payments for HBO therapy in accordance with Medicare requirements for 5 claims. However, First Coast made payments for HBO therapy services that did not comply with Medicare requirements for 110 claims, resulting in overpayments totaling $351,970. OIG treated five claims as non-errors because one was canceled and the Recovery Audit Contractor indicated that the other four were under review by another entity.

OIG made the following recommendations to First Coast: (1) recover the appropriate portion of the $351,970 in Medicare overpayments; (2) notify the providers responsible for the 46,737 non-sampled claims with potential overpayments estimated at $39.3 million so that those providers can investigate and return any identified overpayments; (3) identify and recover any improper payments for HBO therapy services made after the audit period, and (4) work with CMS to the extent possible in developing more effective automated HBO therapy prepayment edits in the claim processing system, which would result in millions of dollars in future cost savings.

Work Plan #: A-04-16-06196; W-00-16-35780
Government Program: Medicare Parts A & B

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Provider

Review of Outpatient 3-Dimensional Conformal Radiation Therapy Planning Services

3-Dimensional Conformal Radiation Therapy (3D-CRT) is a radiation therapy technique that allows doctors to sculpt radiation beams to the shape of a patient's tumor. 3D-CRT is provided in two treatment phases: planning and delivery. Hospitals bill Medicare for developing a 3D-CRT treatment plan using Current Procedural Terminology code 77295. Automated prepayment edits prevent additional payments for separately billed radiation planning services if they are billed on the same date of service as the 3D-CRT treatment plan. However, Medicare allows additional payments if they are billed on a different date of service (e.g., 1 day before). For a form of radiation similar to 3D-CRT, Medicare requirements prohibit payments for separately billed radiation planning services when they are billed on a different date of service. OIG determined the extent of potential savings to Medicare if it had implemented the same requirements for 3D-CRT planning services.

SunHawk Summary of OIG Findings and Recommendations

OIG reported Medicare could have saved $125.4 million from CYs 2008 through 2017 by implementing billing requirements and system edits to prevent additional payments for separately billed 3D-CRT planning services. These services were primarily billed on a different date of service from the procedure code for development of a 3D-CRT treatment plan. As of January 9, 2019, Medicare had paid $13.6 million for separately billed 3D-CRT planning services performed in CY 2018.

OIG recommended CMS implement billing requirements (including, for example, a bundled payment similar to that for IMRT) and system edits to prevent additional payments for 3D-CRT planning services that are billed before (e.g., up to 14 days before) the procedure code for the 3D-CRT treatment plan is billed, which could have saved Medicare as much as $125.4 million during CYs 2008 through 2017 and as much as $13.6 million in CY 2018.

Work Plan #: A-09-18-03026; W-00-18-35812
Government Program: Medicare Parts A & B

Hospitals' Reliance on Drug Compounding Facilities

Large-scale facilities that compound without a patient-specific prescription are regulated under section 503B of the Food, Drug and Cosmetic Act and referred to as outsourcing facilities. OIG determined the extent to which hospitals obtain compounded sterile preparations from compounders, including outsourcing facilities that have registered with the Food and Drug Administration. OIG also determined the extent to which compounders that produce compounded sterile preparations without a patient-specific prescription have registered with the Food and Drug Administration.

SunHawk Summary of OIG Findings and Recommendations

OIG reported most hospitals that obtained non-patient specific compounded drugs from outside compounders obtained them from what the Food and Drug Administration (FDA) calls outsourcing facilities—compounders that are registered with FDA. In fact, 89 percent of hospitals that obtained non-patient-specific compounded drugs did so exclusively from outsourcing facilities, 9 percent of such hospitals obtained at least some from outsourcing facilities, and just 2 percent

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obtained them exclusively from unregistered compounders. OIG provided FDA with a list of compounders sorted by registration status, which it can use to prioritize follow up.

OIG recommended the FDA further communicate with hospitals about the importance of obtaining their non-patient-specific compounded drugs from outsourcing facilities. OIG also recommended the FDA take appropriate follow up actions with the unregistered compounding facilities on the list that OIG provided; these facilities may not be in compliance with Federal law.

Work Plan #: OEI: 01-17-00090
Government Program: Medicare Parts A & B

Patient Safety Organizations: Hospital Participation, Value, and Challenges

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

SunHawk Summary of OIG Findings and Recommendations

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

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

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

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Provider

Long Term Care

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

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

California

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

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

Missouri

OIG reported Missouri 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 onsite inspections, OIG identified deficiencies in areas related to life safety and emergency preparedness at all 20 nursing

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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 make other procedural recommendations to Missouri regarding the development of standardized life safety training for nursing home staff, the conducting of more frequent surveys and follow-up at nursing homes with a history of multiple high-risk deficiencies, and updates of facility-specific plans.

Texas

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.

Florida

OIG reported Florida did not ensure that selected nursing homes that participated in the Medicare or Medicaid programs complied with CMS and State requirements for life safety and emergency preparedness. 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. OIG also made other administrative recommendations.

Work Plan #: A-04-18-08065 (FL), A-09-18-02009 (CA), A-07-18-03230 (MO), A-06-19-08001 (TX)
Government Program: Medicare Parts A & B

Skilled Nursing Facility Prospective Payment System Requirements

Medicare requires a beneficiary to be an inpatient of a hospital for at least 3 consecutive days before being discharged from the hospital to be eligible for SNF services (SSA § 1861(i)). If the beneficiary is subsequently admitted to an SNF, the beneficiary is required to be admitted either within 30 days after discharge from the hospital or within such time as it would be medically appropriate to begin an active course of treatment. Prior OIG reviews found that Medicare payments for SNF services were not compliant with the requirement of a 3-day inpatient hospital stay within 30 days of an SNF admission. OIG reviewed compliance with the SNF prospective payment system requirement related to a 3-day qualifying inpatient hospital stay.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that CMS improperly paid 65 of the 99 SNF claims OIG sampled when the 3-day rule was not met. Improper payments associated with these 65 claims totaled $481,034. On the basis of OIG's sample results, OIG estimated that CMS improperly paid $84 million for SNF services that did not meet the 3-day rule during CYs 2013 through 2015.

OIG recommended CMS should ensure that the Common Working File (CWF) qualifying inpatient hospital stay edit for SNF claims is enabled when SNF claims are processed for payment. In addition, CMS should require hospitals to provide beneficiaries a written notification of the number of inpatient days of care provided during the hospital stay and whether the hospital stay qualifies subsequent SNF care for Medicare reimbursement so that beneficiaries are aware of their potential financial responsibility before consenting to receive SNF services. CMS should require SNFs to obtain a written notification from the hospital and retain it as a condition of payment for their claims. Further, CMS should educate both hospitals and SNFs about verifying and documenting the 3-day inpatient hospital stay relative to supporting a Medicare claim for SNF reimbursement

Work Plan #: A-05-16-00043; W-00-16-30014
Government Program: Medicare Parts A & B

Long-Term-Care Hospitals - Adverse Events in Post-acute Care for Medicare Beneficiaries

Long-term-care hospitals (LTCHs) are inpatient hospitals that provide long-term care to clinically complex patients, such as those with multiple acute or chronic conditions. Medicare beneficiaries typically enter LTCHs following an acute-care hospital stay to receive intensive rehabilitation and medical care. LTCHs are the third most common type of post-acute

care facility after SNFs and inpatient rehabilitation facilities. LTCHs account for nearly 11 percent of Medicare costs for post-acute care ($5.4 billion in FY 2011). OIG estimated the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving care in LTCHs. OIG also identified factors contributing to these events and determine the extent to which the events were preventable.

SunHawk Summary of OIG Findings and Recommendations

OIG reports finding 21 percent of Medicare patients in LTCHs experienced adverse events, which are particularly serious instances of patient harm resulting from medical care. The four categories of adverse events include outcomes such as prolonging a patient's LTCH stay or necessitating transfer to another facility; requiring life-saving intervention; resulting in permanent harm; and contributing to death.

OIG recommended that the Agency for Healthcare Research and Quality (AHRQ) and CMS should tailor their ongoing efforts to improve patient safety to address the specific needs of LTCHs. OIG recommended that AHRQ and CMS collaborate to create and disseminate a list of potential harm events in LTCHs and that CMS include information about patient harm in its outreach to LTCHs. CMS and AHRQ concurred with OIG's recommendations.

Work Plan #: OEI: 06-14-00530
Government Program: Medicare Parts A & B

Skilled Nursing Facilities - Unreported Incidents of Potential Abuse and Neglect

SNFs are institutions that provide skilled nursing care, including rehabilitation and various medical and nursing procedures. Ongoing OIG reviews at other settings indicate the potential for unreported instances of abuse and neglect. OIG assessed the incidence of abuse and neglect of Medicare beneficiaries receiving treatment in SNFs and determined whether these incidences were properly reported and investigated in accordance with applicable Federal and State requirements. OIG also interviewed State officials to determine if each sampled incident was reported, if required, and whether each reportable incident was investigated and subsequently prosecuted by the State, if appropriate.

SunHawk Summary of OIG Findings and Recommendations

OIG estimated that one in five high-risk hospital ER Medicare claims for treatment provided in calendar year 2016 were the result of potential abuse or neglect, including injury of unknown source, of beneficiaries residing in a SNF. OIG determined that SNFs failed to report many of these incidents to the Survey Agencies in accordance with applicable Federal requirements. OIG also determined that several Survey Agencies failed to report some findings of substantiated abuse to local law enforcement. Lastly, OIG determined that CMS does not require all incidents of potential abuse or neglect and related referrals made to law enforcement and other agencies to be recorded and tracked in the Automated Survey Processing Environment Complaints/Incidents Tracking System.

OIG recommended CMS take action to ensure that incidents of potential abuse or neglect of Medicare beneficiaries residing in SNFs are identified and reported by working with the Survey Agencies to improve training for staff of SNFs on how to identify and report incidents of potential abuse or neglect of Medicare beneficiaries, clarifying guidance to define and provide examples of incidents of potential abuse or neglect, requiring the Survey Agencies to record and track all

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incidents of potential abuse or neglect in SNFs and referrals made to local law enforcement and other agencies, and monitoring the Survey Agencies' reporting of findings of substantiated abuse to local law enforcement.

Work Plan #: A-01-16-00509
Government Program: Medicare Parts A & B

Potentially Avoidable Hospitalizations of Medicare- and Medicaid-Eligible Nursing Facility Residents

High occurrences of patient transfers from nursing facilities to hospitals for potentially preventable conditions could indicate poor quality of care. Prior OIG work identified a nursing facility with a high rate of Medicaid recipient transfers to hospitals for a urinary tract infection (UTI), a condition that is often preventable and treatable in the nursing facility setting without requiring hospitalization. The audit disclosed that the nursing facility often did not provide UTI prevention and detection services in accordance with its residents' care plans, increasing the residents' risk for infection and hospitalization. OIG reviewed nursing homes with high rates of patient transfers to hospitals for potentially preventable conditions and determined whether the nursing homes provided services to residents in accordance with their care plans (42 CFR § 483.25(d)). OIG selected for review Princeton Place Skilled Nursing and Rehabilitation Center (Princeton Place) based on a review of nursing home quality measures, including a high average UTI rate among residents.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that Princeton Place staff did not always document that they monitored the residents' urine appearance at the frequencies specified in their care plans and that Princeton Place did not have policies and procedures to ensure that its staff provided services in accordance with its residents' care plans. As a result, OIG reported that Princeton Place did not following residents' care plans, the residents were at increased risk for contracting UTIs and for incurring complications from UTIs, including requiring hospitalization.

OIG recommended Princeton Place develop and implement policies and procedures requiring that: (1) its nursing staff follow and document compliance with the residents' care plans and (2) supervisors conduct reviews to ensure that the nursing staff follows the residents' care plans.

Work Plan #: A-06-17-02002; W-00-17-35792
Government Program: Medicaid

National Background Checks for Long-Term-Care Employees - Mandatory Review

The Patient Protection and Affordable Care Act provides grants to States, through Centers for Medicare & Medicaid Services, to implement background check programs of prospective long-term-care employees and providers. The Patient Protection and Affordable Care Act requires that OIG conduct an evaluation of this grant program, known as the National Background Check Program, after its completion (ACA § 6201). For States that closed their grants in the preceding year,

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OIG reviewed the procedures States implemented for long-term-care facilities and providers to conduct background checks on prospective employees who would have direct access to patients. OIG determined the outcomes of the States' programs and whether the checks led to any unintended consequences.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that 10 States that had concluded their participation in the Program by 2016 varied as to the degree to which they achieved implementation of Program requirements. Seven of these 10 States implemented all or most of the selected requirements. Three States did not have the necessary authority through State legislation and could not fully implement background check programs. Of the background checks that 8 of the 10 States conducted, nearly 80,000 resulted in determinations of ineligibility for prospective employees. None of the States reported a reduction in available workforce for long-term-care facilities or providers as a result of the Program.

OIG recommended CMS should take appropriate action to encourage participating States to obtain necessary authorities to fully implement Program requirements.

Work Plan #: OEI: 07-16-00160
Government Program: Medicaid

State Agency Verification of Deficiency Corrections

Federal regulations require nursing homes to submit correction plans to the State survey agency or Centers for Medicare & Medicaid Services for deficiencies identified during surveys (42 CFR § 488.402(d)). Centers for Medicare & Medicaid Services requires State survey agencies to verify the correction of identified deficiencies through on-site reviews or by obtaining other evidence of correction (State Operations Manual, Pub. No. 100-07, § 7300.3). A previous OIG review found that one State survey agency did not always verify that nursing homes corrected deficiencies identified during surveys in accordance with Federal requirements. OIG determined whether State survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that the State agency did not always verify nursing homes' correction of deficiencies identified during surveys in CY 2015 in accordance with Federal requirements.

OIG recommended the State survey agency (1) provide guidance and training to its surveyors to ensure that they properly upload system data and (2) ensure that it obtains, reviews, and verifies adequate documentation that supports all aspects of nursing home correction plans.

Work Plan #: A-04-17-02500; A-04-17-08052; A-07-17-03218; A-07-17-03224; W-00-17-31502; various reviews
Government Program: State Survey Agencies

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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 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
Government Program: Medicare Parts A & B

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

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

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SunHawk Summary of OIG Findings and Recommendations

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

OIG recommended Highlands:

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

OIG reported Highlands declined to comment on the draft report.

Work Plan #: A-06-18-08003
Government Program: Medicare Parts A & B

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Provider

Home Health Service

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 3 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.

SunHawk Summary of OIG Findings and Recommendations

OIG reported for 62 of the 130 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. On the basis of 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. Iowa should also 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 recommends 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
Government Program: Medicaid

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

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

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SunHawk Summary of OIG Findings and Recommendations

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

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

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

Administration for Community Living Oversight of Independent Living Programs

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

SunHawk Summary of OIG Findings and Recommendations

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

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

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

Medicare Home Health Agency Provider Compliance Audit: Residential Home Health

Under the 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.
OIG's objective was to determine whether Residential Home Health (Residential) complied with Medicare requirements for billing home health services on selected types of claims.

SunHawk Summary of OIG Findings and Recommendations

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. On the basis of OIG's sample results, OIG estimated that Residential received overpayments of at least $2 million in CYs 2014 and 2015. All of 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 recommend 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.

Work Plan #: A-05-16-00063
Government Program: Medicare Parts A & B

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Provider

Hospice

Protecting Medicare Hospice Beneficiaries from Harm

OIG produced this study as a companion to Trends in Hospice Deficiencies and Complaints (OEI-02-17-00020), 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. 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 Findings and Recommendations

OIG's report features 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 CMS should seek statutory authority to establish additional, intermediate remedies for poor hospice performance. OIG also recommends 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.

Work Plan #: OEI: 02-17-00021
Government Program: Medicare Parts A & B

Trends in Hospice Deficiencies and Complaints

CMS contracts with State survey agencies to conduct onsite surveys of hospices for certification and in response to complaints. National accreditation organizations, approved by CMS, may also conduct onsite surveys. These surveys assess the extent to which hospices meet Federal health and safety standards and require that surveyors cite hospices with deficiencies if they fail to meet the standards. Previous OIG reports identified numerous vulnerabilities and raised concerns about the limited enforcement actions against poorly performing hospices. As part of OIG's ongoing commitment to address quality of care, OIG determined the extent and nature of hospice deficiencies and complaints and identified trends.

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SunHawk Summary of OIG Findings and Recommendations

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 nationwide in 2016. Most poor performers had other deficiencies or substantiated complaints in the 5-year period. Some poor performers had a history of serious deficiencies.

OIG recommended CMS should (1) expand the deficiency data that accrediting organizations report to CMS and use these 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: 02-17-00020
Government Program: Medicare Parts A & B

Duplicate Drug Claims for Hospice Beneficiaries

Medicare Part A pays providers a daily per diem amount for each individual 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 (A-06-10-00059) found that Medicare may have paid twice for prescription drugs for hospice beneficiaries, once under the Part A per diem rate and again under Part D. OIG followed up on this work and reviewed the appropriateness of Part D drug claims for individuals who are receiving hospice benefits under Part A. OIG also determined whether Part D continued to pay for prescription drugs that should have been covered under the per diem payments made to hospice organizations.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that Medicare Part D paid for drugs in 2016 that hospices should have paid for under the Medicare Part A hospice benefit. On the basis of OIG 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; W-00-17-35802
Government Program: Medicare Part D - Prescription Drug Program

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Provider

Medical Equipment & Supplies

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

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

SunHawk Summary of OIG Findings and Recommendations

OIG reported that not all suppliers complied with Medicare requirements when billing for inhalation drugs. For 81 of the 120 sampled claim lines, suppliers complied with the requirements; however, for the remaining 39 claim lines, 22 suppliers did not comply with documentation requirements (the total below exceeds 39 because 2 claim lines had 2 deficiencies). On the basis of OIG sample results, OIG estimated that $92.5 million paid to suppliers was unallowable for Medicare reimbursement. Medicare contractor oversight was not sufficient to ensure that suppliers complied with documentation requirements.

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

CMS concurred with OIG recommendations and described actions that CMS had taken or planned to take to address OIG recommendations.

Work Plan #: A-09-18-03018
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

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

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

SunHawk Summary of OIG Findings and Recommendations

OIG reported Medicare allowable amounts for certain orthotic devices are not comparable with payments made by select non-Medicare payers. For CYs 2012 through 2015, OIG estimated that Medicare and beneficiaries paid $341.7 million more than select non-Medicare payers on 142 HCPCS codes and $4.2 million less than select non-Medicare payers on 19 HCPCS codes. Of the net $337.5 million payment difference, OIG estimated that Medicare paid $270 million and Medicare beneficiaries paid $67.5 million. OIG identified 95 of the 161 codes for which the Medicare allowable amounts could be adjusted using existing legislative authority to make those amounts comparable with payments made by select non-Medicare payers. For the remaining 66 codes, CMS would be required to seek new legislative authority to make those adjustments.

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

In written comments to OIG's draft report, CMS concurred with OIG recommendations and described CMS's planned payment changes for certain orthotic devices.

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

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Provider

Accountable Care Organizations (ACOs)

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

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

SunHawk Summary of OIG Findings and Recommendations

For 229 of the 240 sampled beneficiary-measures, Sunshine complied with applicable Federal requirements by reporting complete and accurate data on quality measures through the CMS web portal. However, for the remaining 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.

Work Plan #: A-09-18-03019
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

- Hospital
- Long Term Care
- Home Health Service
- Hospice
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- Behavioral Health
- Laboratory
- Pharmacy
- Ambulatory Surgical Centers (ASCs)
- Telehealth
- Other Providers and Suppliers

West Florida 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 us to select two ACOs that had consistently received shared savings payments in order to perform an initial risk assessment of ACOs' reporting of data on quality measures through the CMS web portal. This report covers one of those ACOs. OIG's objective was to determine whether West Florida ACO, LLC (West Florida) complied with applicable Federal requirements when reporting data on quality measures through the CMS web portal.

SunHawk Summary of OIG Findings and Recommendations

For 227 of the 240 sampled beneficiary-measures, West Florida complied with applicable Federal requirements by reporting complete and accurate data on quality measures through the CMS web portal. However, for the remaining 13 sampled beneficiary-measures, West Florida did not comply with requirements. Specifically, the medical records did not support that the beneficiaries (1) should have been either included in or removed from the measure population based on the exclusion criteria or (2) satisfied the conditions of the quality measures. Further, the medical records did not support the reported measurement values or the reported "Patient Reason" exception. Instead, the records supported (1) different measurement values that would have still satisfied the conditions of the quality measure or (2) a "Medical Reason" exception that would have still removed the beneficiary from the measure population. These reporting deficiencies, which did not affect West Florida's overall quality performance score, occurred because according to West Florida officials, the ACO participant staff (1) made clerical errors when entering the data and (2) presumed that the beneficiaries did not have an active diagnosis of depression and did not realize that the beneficiaries should have been removed for meeting the exclusion criteria for the depression screening measure. In addition, according to these officials, physicians find it difficult to distinguish between the two exception reasons and, based on a physician's interpretation, either the "Patient Reason" exception or the "Medical Reason" exception may apply.

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

Work Plan #: A-09-18-03003
Government Program: Medicare Parts A & B

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Provider

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Use of Health Information Technology to Support Care Coordination through ACOs

The MSSP, established by section 3022 of ACA, introduced ACOs into the Medicare program to promote accountability of hospitals, physicians, and other providers for a patient population, coordinate items and services, and encourage investment in infrastructure and redesigned care processes for high-quality and efficient service delivery. OIG will review the extent to which ACOs use health information technology to enhance their care coordination goals. OIG will also identify best practices and possible challenges to the exchange and use of health data for care coordination purposes.

SunHawk Summary of OIG Findings and Recommendations

ACOs that used a single electronic health record (EHR) system across their provider networks were able to share data in real time, enhancing providers' ability to coordinate care. A small number of ACOs had access to robust health information exchanges, which give ACOs access to patient data even when patients see providers outside the ACOs' networks. Most of the ACOs OIG visited used data analytics to inform their care coordination by identifying and grouping patients according to the potential severity and cost of their health conditions.

However, the ACOs OIG visited still face challenges in these areas. ACOs that used multiple EHR systems had to rely on other means to share data among providers, either using additional health IT tools or relying on phone calls and faxes. Although EHRs are intended to streamline, coordinate, and improve care, ACOs report that EHRs can also be burdensome and frustrating for providers. ACOs also faced challenges from physician burnout due to the workload of managing EHRs.

Achieving the interoperability needed for seamless care coordination places burdens on ACOs to either invest in a single EHR system or use other methods, such as non-health IT means, to communicate health information.

rk Plan #: OEI: 01-16-00180
Government Program: Medicare Parts A & B

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

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

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SunHawk Summary of OIG Findings and Recommendations

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

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

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

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Medical Equipment & Supplies

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Behavioral Health

Grand Desert Psychiatric Services: Audit of Medicare Payments for Psychotherapy Services

Medicare paid approximately $2 billion for psychotherapy services provided to Medicare beneficiaries from January 2017 through December 2018 (audit period). Prior OIG reviews found that Medicare had made millions in improper payments for mental health services, including psychotherapy services. These reviews also identified problems with psychotherapy services that were billed in conjunction with evaluation and management (E&M) services. After analyzing Medicare claim data, OIG selected for audit Grand Desert Psychiatric Services (Grand Desert). OIG analysis showed that during OIG audit period, 80 percent of Grand Desert's psychotherapy services were paid in conjunction with E&M services. OIG objective was to determine whether Grand Desert complied with Medicare requirements when billing for psychotherapy services.

SunHawk Summary of OIG Findings and Recommendations

Grand Desert did not comply with Medicare requirements when billing for psychotherapy services. Specifically, of the 100 psychotherapy services in OIG 100 sampled beneficiary days, only 1 service complied with the requirements. However, the remaining 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 sample results, OIG estimated that at least $421,272 was unallowable for Medicare reimbursement, or 93 percent of the $450,663 paid to Grand Desert for psychotherapy services.

OIG recommend 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 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. The report lists one more recommendation.

Work Plan #: A-09-19-03018
Government Program: Medicare Parts A & B

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

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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).
OIG objective was to determine whether IPFs complied with Medicare coverage, payment, and participation requirements for services provided in FYs 2014 and 2015 that resulted in outlier payments.

SunHawk Summary of OIG Findings and Recommendations

For OIG's 160 sampled claims, OIG found that CMS paid 25 claims that did not meet Medicare medical necessity requirements for some or all days of the stay. Based on OIG sample results, OIG estimated that Medicare overpaid IPFs $93 million for FYs 2014 and 2015 for stays that were noncovered or partially noncovered and resulted in outlier payments. However, if the patients had been treated in different settings, Medicare might have covered those treatments. In addition, 142 claims had missing or inadequate medical record elements, including physician certifications. Of those 142 medical records, 12 did not clearly support that the IPF had protected the patient's right to make informed decisions regarding care. OIG estimated that 87 percent of IPF claims for FYs 2014 and 2015 with outlier payments did not meet Medicare medical necessity or medical record requirements. CMS oversight activities were not adequate to prevent or detect the IPFs' errors. Finally, OIG identified three additional areas of concern: (1) outlier payments may have been made for stays that were not unusually costly, (2) beneficiaries used lifetime reserve days to help pay for days when they no longer required inpatient hospitalization but for the unavailability of appropriate posthospitalization placements, and (3) CMS did not track patient falls or fall rates at IPFs.

OIG made seven recommendations to CMS. Although OIG audit covered only IPF inpatient claims that resulted in outlier payments, OIG's recommendations are relevant to nonoutlier claims. CMS concurred with OIG's 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, and (4) consider tracking patient falls or fall rates.

Work Plan #: A-01-16-00508
Government Program: Medicare Parts A & B

Oceanside Medical Group Received Unallowable Medicare Payments for Psychotherapy Services

Medicare paid about $1.9 billion for psychotherapy services provided to beneficiaries nation-wide from July 1, 2015, through June 30, 2017 (audit period). Prior OIG reviews found that Medicare had made millions in improper payments for mental health services, including psychotherapy services. After analyzing Medicare claim data, OIG selected for review Oceanside Medical Group (Oceanside). OIG analysis indicated that providers from Oceanside billed Medicare an average of 33 individual services per day. In addition, two providers each billed for services on all but 5 days during OIG audit period. OIG objective was to determine whether Oceanside complied with Medicare requirements when billing for psychotherapy services.

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SunHawk Summary of OIG Findings and Recommendations

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. On the basis of OIG 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 actually provided, adequately documented, and correctly billed.

OIG recommend that Oceanside (1) refund to the Medicare program the portion of the estimated $2.6 million overpayment for claims that are within he 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 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-09-18-03004
Government Program: Medicare Parts A & B

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

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

SunHawk Summary of OIG Findings and Recommendations

Over 500,000 Medicaid-enrolled children who were newly prescribed an ADHD medication and over 3,500 children who were hospitalized with a primary diagnosis of ADHD did not receive follow-up care within the timeframes outlined in the

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national quality measures. Additionally, over 54,000 children did not receive any behavioral therapy as recommended by professional guidelines.

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

Work Plan #: OEI: 07-17-00170
Government Program: Medicaid

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

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

SunHawk Summary of OIG Findings and Recommendations

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

OIG recommends that the Centers for Medicare & Medicaid Services (CMS) identify States that have limited availability of behavioral health services and develop strategies and share information with them to ensure that Medicaid managed care enrollees have timely access to these services. OIG also recommends that the New Mexico Human Services Department expand New Mexico’s behavioral health workforce that serves Medicaid managed care enrollees. It should also improve access to services by reviewing its access to care standards and by increasing access to transportation, access to broadband, and the use of telehealth. Lastly, it should improve the effectiveness of services by increasing adoption of electronic health records, identifying and sharing information about strategies to improve care coordination, expanding initiatives to integrate behavioral and primary healthcare, and sharing information about open-access scheduling and the Treat First Clinical Model.Work Plan #: OEI: 02-17-00490

Government Program: Medicaid

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Provider

Laboratory

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

Medicare pays a specimen collection fee when it is medically necessary for a clinical laboratory technician to draw a specimen to perform a clinical diagnostic laboratory test. When a technician travels to a nursing facility or homebound patient and a specimen collection fee is payable, the Social Security Act provides for payment of a travel allowance. Prior work found that travel allowances were at risk of being overpaid. For this review, OIG focused on travel allowance payments for clinical diagnostic laboratory tests made by one Medicare administrative contractor (MAC), Wisconsin Physicians Service (WPS), because it was one of the largest payers of travel allowances in the Nation from January 1, 2015, through December 31, 2016 (audit period). The objective of OIG's review was to determine whether payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests complied with Medicare requirements.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that payments made by WPS to providers for travel allowances for clinical diagnostic laboratory tests did not always comply with Medicare requirements. Specifically, OIG claims, 76 of the 109 claim lines in OIG stratified random sample that were reviewed complied with Medicare requirements, but 33 claim lines did not (some lines had multiple deficiencies). WPS made payments to providers for (1) claims with incorrectly calculated prorated mileage, (2) claims using the incorrect clinical laboratory fee schedule rate, and (3) claims without sufficient documentation to support payment. On the basis of OIG sample results, OIG estimated that WPS paid providers $353,755 in travel allowances for clinical laboratory services that were not in accordance with Medicare requirements.

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

Work Plan #: A-06-17-04005
Government Program: Medicare Parts A & B

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Medical Equipment & Supplies

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Payments for Immunosuppressive Drug Claims with "KX" Modifiers

Medicare Part B covers Food and Drug Administration-approved immunosuppressive drugs and drugs used in immunosuppressive therapy when a beneficiary receives an organ transplant for which immunosuppressive therapy is appropriate. Since July 2008, suppliers that furnish an immunosuppressive drug to a Medicare beneficiary annotate the Medicare claim with the "KX" modifier to signify that the supplier retains documentation of the beneficiary's transplant date and that such transplant date preceded the date of service for furnishing the drug (Centers for Medicare & Medicaid Services' Medicare Claims Processing Manual, Pub. No. 100 04, Ch. 17, § 80.3). Prior OIG reports found that Medicare claims for immunosuppressive drugs reported with the "KX" modifier may not always meet documentation requirements for payment under Part B. OIG determined whether Part B payments for immunosuppressive drugs that were billed with a service code modifier "KX" met Medicare documentation requirements.

SunHawk Summary of OIG Findings and Recommendations

OIG reported that pharmacies improperly received $3,973 in Part B reimbursement for the immunosuppressive drugs on the 10 claims. On the basis of OIG's sample results, OIG estimated that Part B paid $4.6 million in reimbursement for immunosuppressive drugs billed with the KX modifier that did not comply with Medicare requirements.

OIG recommended that CMS (1) clarify language in the Manual to be consistent with its intent, as described above, and (2) instruct the claims processing contractors to process immunosuppressive drug claims without the KX modifier and educate pharmacies on the correct use of the modifier.

Work Plan #: A-06-15-00018; W-00-15-35707
Government Program: Medicare Parts A & B

SUNHAWK CONSULTING

Provider

Ambulatory Surgical Centers (ASCs)

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

Medicare sets minimum health and safety requirements for ambulatory surgical centers (ASCs) through the Conditions of Participation. Centers for Medicare & Medicaid Services requires that ASCs become Medicare certified to show they meet these conditions. Previous OIG work found problems with Medicare's oversight system, including finding spans of 5 or more years between certification surveys for some ASCs, poor Centers for Medicare & Medicaid Services oversight of State survey agencies, and little public information on the quality of ASCs. OIG reviewed the frequency and deficiency findings of Medicare's certification surveys for ASCs.

SunHawk Summary of OIG Findings and Recommendations

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

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

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

SUNHAWK CONSULTING

Provider

Telehealth

Texas Telemedicine Services Were Provided in Accordance with State Requirements

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. Medicaid programs have recently demonstrated increased interest in telemedicine services. This audit is one in a series of audits to determine whether selected States complied with Federal and State requirements when claiming Federal reimbursement for telemedicine services. OIG's objective was to determine whether Telemedicine services were allowable in accordance with the Texas Medicaid requirements. Specifically, OIG reviewed whether these services met the technology, patient and provider location, and documentation requirements.

SunHawk Summary of OIG Findings and Recommendations

OIG determined that 39 of the 40 client dates of service OIG reviewed were allowable in accordance with the Texas Medicaid requirements. For the remaining client date of service, 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.

Work Plan #: A-06-18-05001
Government Program: Medicaid

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96 Percent of South Carolina's Medicaid Fee-for-Service Telemedicine Payments Were Insufficiently Documented or Otherwise Unallowable

Medicaid telemedicine services are health services delivered via telecommunication systems. A Medicaid patient at a referring site uses audio and video equipment to communicate with a health professional at a consulting site. Medicaid views telemedicine services as a cost-effective alternative to the more traditional face-to-face way of providing medical care. Medicaid programs are seeing a significant increase in payments for telemedicine services and expect this trend to continue. Telemedicine is expanding in South Carolina, and the State's Medicaid payments for telemedicine services have recently increased. This audit is one in a series of audits to determine whether selected States complied with Federal and State requirements when claiming Federal reimbursement for telemedicine services. OIG objective was to determine whether South Carolina made payments for telemedicine services in accordance with Federal and State requirements.

SunHawk Summary of OIG Findings and Recommendations

OIG reports that South Carolina made telemedicine payments that were not in accordance with Federal and State requirements and were therefore unallowable. Of the 100 Medicaid fee-for-service telemedicine payments in OIG stratified random sample, 3 payments were allowable. However, the remaining 97 payments were 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 actually 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. On the basis of OIG sample results, OIG estimated that 96 percent of South Carolina's Medicaid fee-for service telemedicine payments were unallowable. OIG also estimated that unallowable payments totaled at least $2.1 million ($1.5 million Federal share) during OIG audit period.

OIG recommends 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-04-18-00122
Government Program: Medicaid

SUNHAWK CONSULTING

Provider

Other Providers and Suppliers

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 Findings and Recommendations

OIG reported that BMA claimed reimbursement for dialysis services that did not comply with Medicare requirements during 96 out of 100 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. OIG also made a series of recommendations to strengthen BMA's internal controls to ensure that dialysis services comply with Medicare requirements.

Work Plan #: A-02-17-01016
Government Program: Medicare Parts A & B

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

A prior OIG review found that Medicare made improper and potentially improper payments of $1.9 million to providers for emergency ambulance transports to destinations other than hospitals or skilled nursing facilities (SNFs) with dates of service from calendar years (CYs) 2014 through 2016. As part of that review, OIG identified $3.2 million in payments for emergency ambulance transports from hospitals to SNFs. Because hospitals are capable of providing emergency

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services, OIG conducted this separate review of emergency ambulance transports from hospitals to SNFs to determine the appropriateness of billing for them as emergency ambulance transports. OIG's objective was to determine whether Medicare payments to providers for emergency ambulance transports from hospitals to SNFs complied with Federal requirements.

SunHawk Summary of OIG Findings and Recommendations

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

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

Work Plan #: A-09-18-03030
Government Program: Medicare Parts A & B

Chiropractic Services - Part B Payments for Noncovered Services

Part B pays only for a chiropractor's manual manipulation of the spine to correct a subluxation if there is a neuro-musculoskeletal condition for which such manipulation is appropriate treatment (42 CFR § 410.21(b)). Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable (Centers for Medicare & Medicaid Services' Medicare Benefit Policy Manual, Pub. No. 10002, Ch. 15, § 30.5B). Prior OIG work identified inappropriate payments for chiropractic services. Medicare will not pay for items or services that are not "reasonable and necessary" (SSA § 1862(a)(1)(A)). OIG reviewed Medicare Part B payments for chiropractic services to determine whether such payments were claimed in accordance with Medicare requirements.

SunHawk Summary of OIG Findings and Recommendations

Twin Palms

OIG reported that, of the 100 sampled chiropractic services in our sample, 46 were allowable in accordance with Medicare requirements. However, the remaining 54 services were not allowable: 42 services were medically unnecessary, 11 services were insufficiently documented, and 1 service was incorrectly coded. As a result, Twin Palms received $1,680 in unallowable payments.

OIG recommended Twin Palms: (1) refund to the Federal Government the portion of the estimated $317,038 overpayment for claims for chiropractic services that did not comply with Medicare requirements and are within the 4-year claims reopening period and (2) establish policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary, adequately documented in the medical records, and coded correctly.

Etheredge Chiropractic

OIG reported that, of the 100 sampled chiropractic services in OIG's sample, 67 were allowable in accordance with Medicare requirements. However, the remaining 33 were not allowable: 31 services were medically unnecessary and 2 were not documented. As a result, Etheredge received $1,042 in unallowable payments.

OIG recommended Etheredge: (1) refund to the Federal Government the portion of the estimated $169,737 overpayment for claims for chiropractic services that did not comply with Medicare requirements and are within the 4- year claims reopening period; (2) exercise reasonable diligence to identify and return the overpayments in accordance with the 60-day rule, for the remaining portion of the estimated $169,737 overpayment for claims that are outside of the reopening period, 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, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and (4) establish adequate policies and procedures to ensure that chiropractic services billed to Medicare are medically necessary and adequately documented.

Work Plan #: A-04-16-07065; A-04-16-07064; W-00-16-35606
Government Program: Medicare Part B

Services for American Indians and Alaska Natives Administered by a Federally Qualified Health Center

The Indian Health Service (IHS) provides comprehensive health services to approximately 2 million American Indians and Alaska Natives (AI/AN), either by operating health facilities directly or by funding tribes through contracts or compacts to operate health facilities themselves. In certain cases, tribes may operate a facility known as a Federally Qualified Health Center (FQHC), which is certified by the Centers for Medicare & Medicaid Services to provide outpatient health services to rural areas or underserved populations. In addition to funding from IHS, the tribes may also receive health care funding from the Medicaid or Medicare programs. This work will build on OIG's body of work identifying longstanding challenges, including insufficient oversight and limited access to specialists that likely impact the quality of health care services

SUNHAWK CONSULTING

Provider

Hospital

Long Term Care

Home Health Service

Hospice

Medical Equipment & Supplies

Accountable Care Organizations

Behavioral Health

Laboratory

Pharmacy

Ambulatory Surgical Centers (ASCs)

Telehealth

Other Providers and Suppliers

provided to AI/ANs. OIG reviewed certain tribally operated FQHCs that are funded by IHS to determine whether health services delivered to AI/ANs met applicable Federal requirements.

SunHawk Summary of OIG Findings and Recommendations

Passamaquoddy Tribe's Pleasant Point Health Center (March 2019)

OIG found that PPHC did not utilize a Managed Care Committee (MCC), comprised of the required medical and administrative staff, to review medical referrals on a weekly basis. In addition, Pleasant Point Health Center (PPHC) did not always maintain accurate and complete documentation of medical referrals.

OIG recommended the Passamaquoddy Tribe at Pleasant Point (1) reestablish an MCC, comprised of the required medical and administrative staff, to review medical referrals on a weekly basis in accordance with Federal requirements and (2) implement policies and procedures to maintain complete and accurate documentation of medical referrals.

Passamaquoddy Tribe's Pleasant Point Health Center (July 2018)

OIG reported that the Passamaquoddy Tribe at Pleasant Point did not always meet Federal and Tribal health and safety requirements for the quality of care at PPHC. Specifically, OIG found that PPHC did not always have a physician who provided medical direction for the health center, clear lines of authority and responsibility between medical and administrative decision-making, medical policies and procedures (including pain-management treatment prioritization for opioid prescription and compliance monitoring), and other policies and procedures needed to comply with the requirements.

OIG recommended the Passamaquoddy Tribe at Pleasant Point, including that it (1) ensures PPHC is under the medical direction of a physician, (2) establishes clear lines of authority and responsibility between medical and administrative decision-making, and (3) develops and implements medical policies and procedures to comply with health and safety requirements.

Penobscot Indian Nation

OIG reported that the Penobscot Nation did not meet all Federal and Tribal health and safety requirements for the quality of health care at Penobscot Nation Health Department (PNHD). Specifically, OIG found that PNHD did not have a physician who provided the medical direction for the health center and performed all of the required oversight duties, written patient care policies and procedures (including pain-management and opiate-dependency treatment and compliance monitoring), and other policies and procedures needed to comply with the requirements.

OIG recommended the Penobscot Nation, including that it (1) ensures PNHD is under the medical direction of a physician who performs all of the required duties; (2) develops, approves, and implements written medical policies and procedures with the advice of the required group of professional medical staff; and (3) develops and implements policies and procedures to comply with health and safety requirements.

Work Plan #: A-01-17-01503; A-01-17-01502; A-01-17-01500; W-00-17-59052
Government Program: Indian Health Service (IHS)