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Health Care Regulatory Compliance Hot Topics Roundtable

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This quarter’s lineup

Deloitte & Touche LLP facilitators



Bailey Camp, senior consultant
Facilitator



Nandish Sheth, manager, and Kris Shattuck, senior manager
Acute stroke and malnutrition compliance considerations



Joe DeSimone, senior consultant, and Vincent Iannello, consultant
CMS rules updates



Carsten Lachell, manager, and Katie Gonick, manager
340B compliance changes



Neela Kirankumar, consultant, and Ashley Robalino, analyst
Department of Justice (DOJ) and Office of Inspector General (OIG) enforcement updates

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After the call, we will send out a copy of today's Health Care Regulatory Compliance Hot Topics Roundtable (HRCHT) presentation



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Nandish Sheth and Kris Shattuck

Acute stroke and malnutrition compliance considerations

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Acute stroke diagnosis codes – what happened and what it means

Overpayment finding

CMS potentially **overpaid Medicare Advantage** organizations **$462 million** based on unsupported acute stroke diagnosis codes (OIG Report A-02-23-01020). Organizations should assess their own exposure and implement proactive safeguards now.

Overview

- **Copy/paste & EHR carryover errors:** Historical stroke diagnoses auto-populating into current encounters as if active.
- **Inadequate clinical documentation:** Acute stroke coded without aligned imaging findings, neuro deficits, or explicit physician documentation.
- **Insufficient coding distinctions:** Acute stroke, old/historical infarct, transient ischemic attack (TIA), and sequelae carry different coding & risk adjustment implications — and are frequently conflated.

Compliance considerations

Inpatient / CDI

- Flag when imaging doesn't support acute stroke, neuro deficits are missing, undocumented, or "acute stroke" appears only in the problem list without note support
- Reconcile admitting impression vs. final diagnosis (stroke, TIA, sequelae) to ensure present on admission (POA) accuracy and coding specificity
- Clearly distinguish at admission: acute vs. old infarct, TIA, and sequelae

Outpatient / HCC / MA Risk Adjustment

- All HCC codes require MEAT criteria documented in the current encounter
- Historical/resolved stroke without active management does not satisfy CMS-HCC V28
- Sequelae coding requires separate, specific documentation of functional deficits

Source: CMS Potentially Overpaid Medicare Advantage Organizations $462 Million Based on Certain Unsupported Acute Stroke Diagnosis Codes | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services; CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits | CMS; Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies; ACDIS AHIMA Guidelines for a Compliant Query 2022_addendum2023.pdf

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Acute stroke diagnosis codes – recommended actions

Why act now

Each action below maps directly to one of the three documentation failure patterns OIG identified — **implementation should begin now, ahead of expanded RADV audit activity** across all eligible MA contracts.

Recommended actions

Inpatient

- Conduct proactive stroke case audits: POA accuracy, acute vs. historical distinction, imaging/documentation alignment
- Concurrent CDI to reconcile admitting impression vs. final diagnosis — stroke, TIA, and sequelae distinguished prior to discharge

Outpatient

- Validate stroke-related HCC submissions against CMS-HCC V28 MEAT requirements before submission
- Implement problem list governance: transition resolved strokes from "Active" to "History of" to prevent encounter carryover

Inpatient & outpatient

- Audit EHR problem list workflows for auto-population of historical stroke diagnoses; build OIG detection logic into prospective claims review prior to submission
- Incorporate stroke scenarios into provider, CDI, and coder education — acute/old infarct, TIA, history of, and sequelae distinctions
- Establish denial and takeback monitoring for stroke-coded encounters as standing compliance infrastructure

TEAM Participants

- Accurate stroke documentation protects TEAM target price integrity — HCC codes in the 180-day lookback directly feed episode pricing

The OIG's **$462M finding is a signal, not an outlier**. With RADV audits expanding to all eligible MA contracts, organizations with mature inpatient and outpatient CDI programs and tight coding oversight are best positioned. Those with **unchecked EHR problem list carryover or unresolved documentation gaps** face compounding risk as MA enforcement intensifies.

Source: CMS Potentially Overpaid Medicare Advantage Organizations $462 Million Based on Certain Unsupported Acute Stroke Diagnosis Codes | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services; CMS Rolls Out Aggressive Strategy to Enhance and Accelerate Medicare Advantage Audits | CMS; Announcement of Calendar Year (CY) 2024 Medicare Advantage (MA) Capitation Rates and Part C and Part D Payment Policies; ACDIS AHIMA Guidelines for a Compliant Query 2022_addendum2023.pdf

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Malnutrition care score reporting begins in 2028 — payments follow in FY2030

The mandate touches four functions across the revenue cycle, not just CDI

1

Jul 2026

Final rule issued

CMS adopts the Malnutrition Care Score (MCS) in the Hospital IQR Program

2

2028

Reporting begins

Hospitals begin submitting Malnutrition Care Score data

3

FY2030

Payment impact begins

Mandatory reporting factors into the IPPS payment determination

Quality

Owns MCS methodology and submission — 2 of 4 scored components are diagnosis **documentation** and a **nutrition care plan**

Coding

Assigns severity-specific ICD-10 codes based on what is **documented by a physician or mid – level provider** (E43 = MCC, E44 = CC)

CDI

Bridges dietitian screening and physician attestation so severity is clinically validated

Compliance & Revenue Integrity

Owns audit defensibility and denial exposure tied to the same documentation

Source: FY 2027 IPPS Final Rule Home Page | CMS

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Malnutrition is already a top denial target — the mandate raises the stakes

Below outlines what we consistently see in health systems across the country

Common documentation gaps

- Dietitians screen and identify malnutrition — but physicians never formally attest to the diagnosis
- Severity goes unspecified: “malnutrition” alone loses the CC or MCC entirely
- Clinical indicators (weight loss, reduced oral intake, functional decline, albumin/prealbumin) sit in the chart but are never linked to a formal diagnosis
- Dietitian, nursing, and physician documentation conflict — creating coding compliance risk and making the diagnosis harder to defend under audit
- No shared definition (e.g., ASPEN or GLIM criteria) across payers, dietitians, coders, and physicians for what qualifies as malnutrition

E44 = CC | E43 (severe) = MCC

Severity documentation determines DRG weight — an unspecified diagnosis forfeits the reimbursement and risk-adjustment impact entirely.

A top recovery audit contractor and commercial-payer denial target

Severe malnutrition already faces some of the highest clinical-validation denial rates of any MCC — before the mandate adds reporting pressure on top.

Better documentation isn't just a quality metric — it's a compliance and revenue protection strategy.

Source: FY 2027 IPPS Final Rule Home Page | CMS

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One missed step lowers the score — closing the gap starts before 2028

How the four MCS components combine into a score, and the five checks that catch gaps before the claim goes out

1. Screening
Nurse or RD/RDN

→

2. Assessment
RD/RDN

→

3. Diagnosis
Physician

→

4. Care Plan
RD/RDN

Score per encounter = 100 × (steps completed ÷ steps clinically required)

All 4 steps documented
Screening, assessment, diagnosis, and care plan all completed
100%

Physician diagnosis missing
Screened and assessed severe, care plan done — no physician attestation
75%

Five checks before the claim goes out (pre-bill review)

1. **Physician attestation**
2. **Severity alignment**
3. **Clinical indicator support**
4. **Documentation consistency**
5. **POA status accuracy**

A gap at any single step pulls the score down — pre-bill review is the last checkpoint to catch it before 2028 becomes a hard deadline.

Source: FY 2027 IPPS Final Rule Home Page | CMS; Malnutrition Care Score | eCQI Resource Center

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The electronic clinical quality measure (eCQM) doesn't mandate a tool — just a coded at-risk result

MST, MUST, and MNA-SF are three (3) validated screening tools commonly used to satisfy the first step

MST

Malnutrition Screening Tool

Administered by: Nurse, at admission

- Unintentional recent weight loss (and how much)
- Reduced appetite or food intake

Fastest, most widely used for the initial inpatient screen

MUST

Malnutrition Universal Screening Tool

Administered by: Nurse or clinician

- Body mass index (BMI)
- Percentage unplanned weight loss (3–6 months)
- Acute disease effect (little/no intake for >5 days)

Adds an acute-illness component beyond MST

MNA-SF

Mini Nutritional Assessment — Short Form

Administered by: Nurse or clinician

- Decline in food intake (past 3 months)
- Weight loss
- Mobility
- Recent acute illness or psychological stress
- Neuropsychological problems
- BMI (or calf circumference)

More detailed; common in geriatric-focused units

What to audit now: Trace 10 charts from screening to submission. If the "at risk" result isn't landing in a structured field mapped to CMS's value set, the eCQM will miss it — no matter which tool was used.

Source: FY 2027 IPPS Final Rule Home Page | CMS; Malnutrition Care Score | eCQI Resource Center

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Joe DeSimone and Vincent Iannello

CMS proposed rule updates

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Remote patient monitoring: a proposed overhaul

CMS's CY 2027 proposal would tighten RPM and RTM billing requirements across clinical staffing, patient initiation, eligibility, reimbursement, and future coding.

What's changing

Third-party vendor ban:
Medicare would pay for Remote Physiological Monitoring (RPM) and Remote Therapeutic Monitoring (RTM) only when furnished by clinical staff directly employed by the billing practice — not contracted vendors. Staff need not be on-site.

RTM limited to established patients:
RTM no longer available for new-patient monitoring.

Initiating visit required:
A separately reportable visit must precede the start of RPM/RTM services.

Payment changes:
Practice-expense valuations cut for several codes; CMS is also seeking comment on consolidating codes into four new G-codes.

Carve-out:
Inpatient monitoring and Acute Hospital Care at Home are unaffected — both are bundled into the DRG payment.

Why it's on the radar

Growth in outsource model:
60–70% of hospitals/health systems use partially or fully outsourced RPM/RTM vendor models today (ATA estimate) — only 30–40% operate fully in-house.

Grounded in OIG findings:
43% of RPM enrollees missed a required service component (2024); payments rose 31% to $536M with ~1M enrollees (2025).

Broad opposition:
AHA, MGMA, and telehealth/vendor coalitions have raised concerns, and Congress is separately advancing bills to expand RPM access.

Signal to watch:
Industry observers expect CMS may soften the third-party provision in the final rule — but plan for it as proposed.

If finalized, CMS would require practices to control the clinical side of RPM/RTM. Vendors could continue providing technology and devices, but billable monitoring activities would need to be performed by directly employed staff and supported by appropriate patient initiation, eligibility, and documentation processes.

Source: Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule | CMS

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PFS and ASC proposed changes: reimbursement & payment impact

The PFS and OPPS/ASC proposals tie reimbursement more closely to billing precision, provider eligibility, site-of-service logic, quality reporting, and EMTALA administrative readiness.

PHYSICIAN FEE SCHEDULE (PFS)

Reimbursement pressure ahead

Both conversion factors decline (-1.19% / -1.68%) as the one-year statutory boost expires — expect this to resurface in budget conversations with clinical leadership.

Same-day billing draws scrutiny

Paying the highest-value same-day service at 100% and other applicable services at 50% raises the stakes on E/M-plus-procedure billing — a natural audit and coding-education focus.

Coding & eligibility complexity rises

A restructured G2211, a new Accountable Care Organization (ACO)-specific modifier, and narrower Medicare eligibility rules all add steps to coding accuracy and intake/eligibility verification workflows.

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM (OPPS) & AMBULATORY SURGICAL CENTER (ASC)

Quality reporting has real dollars attached

The 2.4% OPPS/ASC payment update only reaches facilities that meet quality reporting requirements — a reminder to confirm reporting completeness before year-end.

Site-of-service errors get costlier

638 more services move to allowable outpatient status, continuing a multi-year shift — worth revisiting site-of-service determination logic to avoid billing in the wrong setting.

EMTALA oversight shifts to your accreditor

Accrediting organizations would gain authority to assess EMTALA administrative items (signage, ED logs, on-call lists) during routine surveys — get these audit-ready before your next visit.

Source: Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule | CMS; Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (CMS-1850-P) | CMS

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Price transparency & program integrity

Requests for Information and oversight measures across the CY2027 rules

Hospital Price Transparency Request for Information (HPT RFI)

CMS is requesting comment on strengthening machine-readable file (MRF) requirements — including standardizing reporting of outlier payments, stop-loss provisions, rate tiering, and carve-outs — and on the consumer-friendly display, including the deemed-compliance policy for price-estimator tools and the required shoppable-services list. No proposed regulatory text yet; this signals where enforcement focus may be headed.

Star rating overhaul

Overall Hospital Quality Star Rating methodology would place greater weight on the Safety of Care measure group and cause a reduction for low performers.

Quality measure removal

The 'Appropriate Follow-Up Interval for Normal Colonoscopy' measure is proposed for removal from both the OQR and ASCQR programs.

Prior authorization expanded

Prior authorization would extend to 8 additional botulinum toxin injection codes as a program-integrity, volume-control measure.

Source: Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule | CMS; Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (CMS-1850-P) | CMS

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What this means for your compliance program

Compliance leaders should build visibility into RPM/RTM, billing, transparency, EMTALA, and 340B exposure now—while maintaining flexibility until CMS finalizes the rules.

1

Inventory RPM/RTM arrangements now

Map every third-party vendor contract and staffing model against the proposed employment requirement before the comment period closes.

2

Watch the comment & final-rule timeline

PFS and OPPS/ASC comment periods have passed. Build monitoring into your regulatory tracker.

3

Get ahead of price transparency

The HPT RFI signals where standardization and enforcement may move next — a good moment to stress-test your MRF and display compliance.

4

Update coding & billing workflows

E/M-global overlap rules, the G2211 modifier shift, and EMTALA's AO deeming authority all touch documentation and audit readiness.

5

Stress-test your RPM exposure

Consider where your organization is most exposed if the RPM/RTM provision is finalized as proposed — a useful gut-check for your risk assessment.

6

Prepare for 340B payment changes

A proposed cut to 340B drug payments carries significant revenue-cycle implications — covered in detail during our next section

Source: Calendar Year (CY) 2027 Medicare Physician Fee Schedule Proposed Rule | CMS; Calendar Year 2027 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Proposed Rule (CMS-1850-P) | CMS

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Carsten Lachell and Katie Gonick

340B compliance changes

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OPPS proposed ruling for Part B drugs

The Centers for Medicare & Medicaid Services (CMS) is proposing to cut Medicare Part B reimbursement for 340B drugs. If finalized, this reduction would be a 37% relative decrease in reimbursement. This proposed rule would result in severely compressing covered entity (CE) margins on 340B-acquired drugs.

How we got here

Prior legal setback

CMS' 2018 340B payment cut was 30% and struck down by the Supreme Court on procedural grounds

Stronger CMS defense

CMS performed an acquisition cost survey to better support the 2026 proposal

High litigation risk

CEs are likely to argue the rule undermines the 340B program's purpose and the 50% response rate on the survey was inadequate[1]

Financial Impact

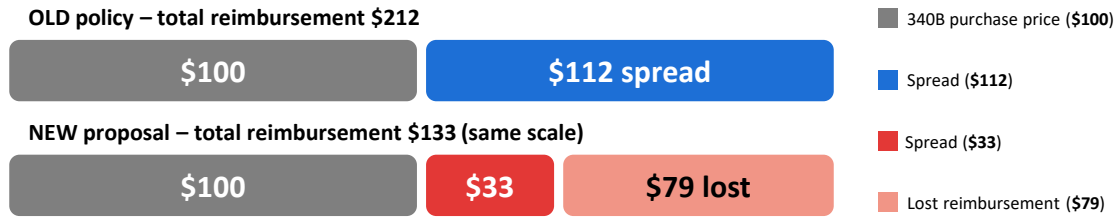
- **Part B rate cut:** ASP+6% to ASP-33.4% (average sales price) effective Jan. 1, 2027—decreasing the spread between CE acquisition cost and Medicare reimbursement
- **Budget Neutrality Offset:** CMS proposes a ~$4.85B reduction in 340B drug payments in 2027. This will be offset by an 8.4% increase for non-drug OPPS services for all hospitals. This may help to partially offset the drug reimbursement reduction
- **Remedy offset increase:** Acceleration of the reduction to recoup increased non-drug payments from 0.5% to 3%, adding ~$2.3B in hospital losses
- **Service line pressure:** Oncology and infusion margins are compressed as they carry the heaviest concentration of Part B drugs

Compliance and Financial Considerations

- **340B billing accuracy:** CEs must accurately identify whether each drug was purchased under the 340B discount. Misclassification creates more than a reimbursement error—it can trigger overpayment recoveries, false-claims exposure, and clawbacks
- **Financial modeling and service line impact:** Revenue cycle, finance, pharmacy, and compliance teams must work together to model service-line revenue impacts. Compliance should validate that the model's assumptions and inputs are accurate and complete
- **Why compliance matters:** Compliance is not just a control function, it also enables CEs to protect margin without increasing audit exposure. Organizations that embed it early will be better positioned than those treating it as a late-stage checkbox

Conceptualizing the financial impact

OLD policy – ASP +6%		PROPOSED policy – ASP -33.4%	
340B purchase price	$100	340B purchase price	$100
ASP	$200	ASP	$200
Medicare pays	$212	Medicare pays	$133
Spread	**$112**	Spread	**$33**



1 - AHA Urges CMS Not to Finalize OPPS Proposals to Accelerate Clawback and Cut 340B Reimbursements | AHA

Neela Kirankumar and Ashley Robalino

DOJ / OIG update

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Spring 2026 semiannual OIG report to Congress

HHS-OIG'S Semiannual Report to Congress describes OIG's work relating to the administration of HHS programs and operations that were disclosed during the semiannual reporting period from October 1, 2025-March 31, 2026.

Category	Metric	Value
Monetary Impact	Total Monetary Impact	$5.56B
	Return on Investment	$12.70 per $1 invested
Oversight Activities	Reports Issued	78
	Investigations Completed	881
	Recommendations Implemented	182
Enforcement Actions	Excluded Individuals and Entities	1,212

Key enforcement focus areas

1 Post Acute Care

- The OIG highlighted the sentencing of **four California hospice operators to prison terms** ranging from 15 to 57 months
- A major OIG evaluation revealed ongoing, systemic vulnerabilities regarding the **inappropriate use of antipsychotic drugs** on residents with dementia.
- In New Jersey, 10 nursing home owners and related entities were hit with **indefinite federal exclusions**

2 Physician Practices & Software Vendors

- OIG successfully targeted a massive network where defendants accepted **hundreds of millions of dollars in illegal kickbacks**
- The CEO of a healthcare software company was sentenced to **15 years in prison and ordered to pay $452 million in restitution due to fake diagnoses,** allowing the company to bill for highly profitable, medically unnecessary medical equipment and tests

3 Hospitals & Health Systems

- In one simulated penetration and audit done by OIG of a large health system in the Southeast, the **OIG successfully used a phishing campaign to capture login credentials,** because the hospital lacked multifactor authentication (MFA) on its web-based account management systems

OIG Corporate Integrity Agreements Overview

113
Active agreements as of today

$15.9M
Reportable events this fiscal year

16
New agreements the last 12 months

Source: Spring 2026 Semiannual Report to Congress | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services | Browse CIAs | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

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Health care fraud – post acute care

Regulatory enforcement themes

OIG audits continue to flag home health and hospice providers for billing and coding errors, lapses in face-to-face and eligibility documentation, and weak internal controls over claims review. Sampled-claim audits are producing multi-million-dollar extrapolated overpayment estimates, underscoring the need for routine self-audits and staff training to stay ahead of federal recovery actions.

Medicare Home Health Agency Compliance Audit: Deistic Home Health Care, Inc.

- **Federal Charge:** OIG audit found Deistic Home Health Care, Inc. out of compliance with Medicare billing requirements for home health claims paid under Medicare Part A. This was part of a nationwide series of home health audits.
- **Alleged Scale:** Of $15,301,644 in Medicare payments reviewed for the 2021-2022 audit period, Deistic was estimated to have received at least $43,074 in net overpayments.
- **Alleged Mechanics:** Of 100 sampled claims, 37 failed to meet Medicare requirements, 36 for billing/coding errors and 5 for missing face-to-face encounter documentation.
- **Concealment and Structuring:** Errors persisted because Deistic did not consistently review medical record documentation before billing, allowing noncompliant claims to pass through undetected.

Hospice of the Valley – West Received at Least $8.6 Million in Medicare Overpayments

- **Federal Charge:** OIG audit found Hospice of the Valley – West (HOV) billed Medicare Part A for hospice services that did not meet eligibility and coverage requirements.
- **Alleged Scale:** Of 100 sampled hospice claims, 15 did not comply with Medicare requirements, producing $69,184 in overpayments within the sample.
- **Alleged Mechanics:** The errors occurred primarily because HOV did not always follow its policies and procedures to prevent the incorrect billing of Medicare claims for hospice services.
- **Recommendations:** It was recommended that HOV refund to the estimated overpayments for claims for hospice services, consider conducting internal audits or investigations for claims, and provide additional training to clinical personnel

Source: Medicare Home Health Agency Provider Compliance Audit: Deistic Home Health Care, Inc. | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services | Hospice of the Valley - West Received at Least $8.6 Million in Medicare Overpayments | Office of Inspector General | Government Oversight | U.S. Department of Health and Human Services

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Health care fraud – medical necessity DOJ & false claims

Regulatory enforcement themes

Recent enforcement activity shows government scrutiny extending from major fraud to everyday **billing accuracy, spanning criminal prosecutions, civil settlements**, and **routine audits**. Common threads include unnecessary testing, unsupported documentation, and kickback-driven referrals. **Multi-agency coordination, data analytics**, and **Corporate Integrity Agreements** are becoming standard tools, with providers facing penalties—even absent a formal fraud finding—if compliance programs fall short.

Arkansas-based anatomic pathology laboratory and Its Owners Pay $30M to Settle Allegations of Kickbacks and Unnecessary Medical Testing

- **Federal Charge**: An Arkansas-based anatomic pathology laboratory agreed to pay $30 million to resolve False Claims Act allegations of unlawful kickbacks and medically unnecessary pathology testing.
- **Alleged Scale**: The conduct spanned 2015 through July 2022, plus a related kickback arrangement from November 2018 to November 2020.
- **Alleged Mechanics**: Labs were set up inside gastroenterology practices in exchange for exclusive referrals, then auto-ordered special stains and confirmatory tests before a pathologist determined they were needed.
- **Concealment and Structuring**: The lab paid kickbacks to referring practices and a 4% commission to an individual steering providers toward its nerve fiber density testing.

National Health Care Fraud Takedown Results in 455 Defendants Charged in Connection with Over $6.5 Billion in Alleged Fraud

- **Federal Charge**: The medical director of a Florida cardiovascular testing and treatment practice was charged in connection with an $89 million scheme to bill health care benefit programs for unnecessary cardiovascular tests performed on student athletes.
- **Alleged Scale**: The scheme generated $89 million in fraudulent billings tied to cardiovascular testing conducted on student athletes at school campuses.
- **Alleged Mechanics**: The defendant and co-conspirators allegedly used fear-based marketing to drive student athletes to testing, then rubber-stamped results as normal without properly reviewing them.
- **Concealment and Structuring:** The defendant allegedly falsified diagnoses so programs would pay for the testing.

Source: Arkansas Pathology Laboratory and Its Owners Pay $30M to Settle Allegations of Kickbacks and Unnecessary Medical Testing | National Health Care Fraud Takedown Results in 455 Defendents Charged in Connection with over $6.5 Billion in Alleged Fraud

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Health care fraud – Medicare compliance/providers

Regulatory enforcement themes

Recent OIG audit activity reflects sustained federal scrutiny of Medicare payment integrity, even without allegations of intentional fraud. Common threads include **noncompliant documentation, billing misclassification,** and **payment system edits** that fail to catch errors before funds go out. The recurring theme is structural signifies that **gaps in contractor oversight, coverage policy,** and **provider education** are driving **improper payments at scale**. Providers and MACs without robust internal controls face mounting overpayment exposure — even absent any claim of bad faith.

Medicare Improperly Paid Physicians an Estimated $15.2 Million for Sacroiliac Joint Injections

- **Federal Charge**: OIG audit found that Medicare improperly paid physicians an estimated $15.2 million for sacroiliac joint injections that did not comply with Medicare coverage and billing requirements.
- **Alleged Scale**: The audit period ran from October 1, 2023, through September 30, 2024, covering 186,842 total sessions nationwide, of which an estimated 134,526 sessions were improperly paid.
- **Alleged Mechanics:** Of 100 sampled sessions, 72 failed to meet Medicare requirements and 25 didn't meet billing guidance. OIG also estimated 46,711 sessions were misbilled as therapeutic injections
- **Concealment and Structuring**: Root cause was insufficient CMS/MAC oversight.

Wisconsin Physicians Service Insurance Corporation Made Incorrect Medicare Payments to Providers for Outpatient Services

- **Federal Charge:** OIG audit found WPS, a Medicare Administrative Contractor, made incorrect Part B payments to providers for outpatient services, resulting in overpayments of at least $140,182.
- **Alleged Scale**: Audit period: January 2022–December 2023. Of 801 sampled claim lines (50 providers, Jurisdiction 5), 138 were incorrect and 31 more ($76,640) lacked supporting documentation.
- **Alleged Mechanics:** Errors included incorrect modifiers (54 lines, $77,556), unallowable services (14 lines, $34,379), and wrong units of service (16 lines, $28,247).
- **Concealment and Structuring**: Errors stemmed from provider clerical mistakes and gaps in WPS's system edits.

Source: Medicare Improperly Paid Physicians an Estimated $15.2 Million for Sacroiliac Joint Injections | Wisconsin Physicians Service Insurance Corporation Made Incorrect Medicare Payments to Providers for Outpatient Services

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Open discussion

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Polling questions

Which of the topics from today's agenda were you most interested in?

You may select multiple answers

a) Acute stroke and malnutrition compliance considerations

b) CMS proposed rule updates

c) 340B compliance changes

d) OIG/DOJ updates

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Write in question

What topics would you like to hear more about?

Please submit your answer via the webinar Q&A or Chat functions

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