Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

INAPPROPRIATE PAYMENTS TO SKILLED NURSING FACILITIES COST MEDICARE MORE THAN A BILLION DOLLARS IN 2009

Daniel R. Levinson
Inspector General

November 2012
OEI-02-09-00200

EXECUTIVE SUMMARY: INAPPROPRIATE PAYMENTS TO SKILLED NURSING FACILITIES COST MEDICARE MORE THAN A BILLION DOLLARS IN 2009
OEI-02-09-00200

WHY WE DID THIS STUDY

In recent years, the Office of Inspector General has identified a number of problems with billing by skilled nursing facilities (SNF), including the submission of inaccurate, medically unnecessary, and fraudulent claims. Further, the Medicare Payment Advisory Commission has raised concerns about SNFs' improperly billing for therapy to obtain additional Medicare payments. In fiscal year (FY) 2012, Medicare paid $32.2 billion for SNF services.

HOW WE DID THIS STUDY

We based this study on a medical record review of a stratified random sample of SNF claims from 2009. The reviewers determined whether the information reported by the SNFs on the Minimum Data Set (MDS) was supported by and consistent with the medical record. The MDS is a standardized tool that SNFs use to assess each beneficiary. SNFs use the information on the MDS to classify beneficiaries into resource utilization groups (RUG). The RUGs determine how much Medicare pays the SNFs.

WHAT WE FOUND

SNFs billed one-quarter of all claims in error in 2009, resulting in $1.5 billion in inappropriate Medicare payments. The majority of the claims in error were upcoded; many of these claims were for ultrahigh therapy. The remaining claims in error were downcoded or did not meet Medicare coverage requirements. In addition, SNFs misreported information on the MDS for 47 percent of claims. SNFs commonly misreported therapy, which largely determines the RUG and the amount that Medicare pays the SNF.

WHAT WE RECOMMEND

We recognize that the Centers for Medicare & Medicaid Services (CMS) has recently made several significant changes to SNF payments. However, more needs to be done to reduce inappropriate payments to SNFs. We recommend that CMS: (1) increase and expand reviews of SNF claims, (2) use its Fraud Prevention System to identify SNFs that are billing for higher paying RUGs, (3) monitor compliance with new therapy assessments, (4) change the current method for determining how much therapy is needed to ensure appropriate payments, (5) improve the accuracy of MDS items, and (6) follow up on the SNFs that billed in error. CMS concurred with all six recommendations.

TABLE OF CONTENTS

OBJECTIVES

1. To assess the appropriateness of Medicare payments for skilled nursing facility (SNF) claims in 2009.
2. To determine the extent to which SNFs misreported information that affects Medicare payments.

BACKGROUND

SNFs provide skilled nursing care, rehabilitation services, and other services to Medicare beneficiaries who meet certain conditions. In fiscal year (FY) 2012, Medicare paid $32.2 billion for SNF services.[1]

The Office of Inspector General (OIG) has identified a number of problems with SNF billing. Notably, OIG found that 26 percent of claims submitted by SNFs in FY 2002 were not supported by the medical record, representing $542 million in potential overpayments.[2] Recent OIG investigations have also found problems with SNF billing. For example, one SNF reached a settlement agreement on allegations of fraudulent billing for medically unnecessary therapy.[3]

Further, the Medicare Payment Advisory Commission (MedPAC) has raised concerns about SNFs' improperly billing for therapy to obtain additional Medicare payments. Specifically, MedPAC noted that the payment system "encourages SNFs to furnish therapy, even when it is of little or no benefit."[4]

This study is part of a larger body of work about SNF payments and quality of care. The first study found that from 2006 to 2008, SNFs increasingly billed for higher paying categories, even though beneficiary

[1] Centers for Medicare & Medicaid Services (CMS), *2012 CMS Statistics*, Table III.6. Accessed at https://www.cms.gov/ResearchGenInfo/02_CMSStatistics.asp on September 14, 2012.

[2] OIG, *A Review of Nursing Facility Resource Utilization Groups*, OEI-02-02-00830, February 2006.

[3] Department of Justice, *Council Bluffs Area Nursing Home Reaches Settlement Agreement on Allegations of Fraudulent Billing to Medicare for Physical, Occupational, and Speech Therapy Services*, June 28, 2012. Accessed at http://www.justice.gov/usao/ias/news/2012/Bethany%20Lutheran%20Homes%206-28-2012.html on July 12, 2012.

[4] MedPAC, *Report to Congress: Promoting Greater Efficiency in Medicare*, ch. 8, p. 191, June 2007. MedPAC reiterated this concern in response to the planned payment changes in FY 2011. See *Report to Congress: Medicare Payment Policy*, ch. 7, p. 151, March 2011.

characteristics remained largely unchanged.[5] Another study will assess the extent to which SNFs met certain Federal requirements regarding the quality of care provided to beneficiaries.[6]

Medicare Coverage Requirements for Part A SNF Stays

The Part A SNF benefit covers skilled nursing care, rehabilitation services, and other services. These services commonly include physical, occupational, and speech therapy; skin treatments; and assistance with eating, bathing, and toileting. Medicare covers these services for up to 100 days during any spell of illness.[7]

To qualify for the SNF benefit, the beneficiary must have been in the hospital for at least 3 consecutive days and the hospital stay must have occurred within 30 days of admission to the SNF.[8] The beneficiary must need skilled services daily in an inpatient setting and must require the skills of technical or professional personnel to provide these services.[9] In addition, these services must be ordered by a physician and be for the same condition that the beneficiary was treated for in the hospital.[10]

Medicare Payments to SNFs

Medicare pays SNFs under a prospective payment system. SNFs use a standardized tool known as the Minimum Data Set (MDS) to assess each beneficiary's clinical condition, functional status, and expected and actual use of services.[11] SNFs use certain items on the MDS to classify beneficiaries into resource utilization groups (RUG).[12] The RUGs determine how much Medicare pays the SNF.

---

[5] OIG, *Questionable Billing in Skilled Nursing Facilities*, OEI-02-09-00202, December 2010.

[6] OIG, *Medicare Requirements for Quality of Care in Skilled Nursing Facilities*, OEI-02-09-00201, forthcoming.

[7] Social Security Act, § 1812(a)(2)(A), 42 U.S.C. § 1395d(a)(2)(A).

[8] 42 CFR §§ 409.30(a).

[9] 42 CFR §§ 409.31(b)(1) and (3) and 409.31(a)(2).

[10] 42 CFR § 409.31. Medicare also covers SNF services if the condition requiring such services arose when the beneficiary was receiving care in a SNF for a condition treated during the prior hospital stay.

[11] The MDS is part of CMS's Resident Assessment Instrument (RAI). CMS, *Revised Long-Term Care Facility Resident Assessment Instrument User's Manual Version 2.0 (RAI Manual 2.0)*, Dec. 2002, rev. Dec. 2005, § 1.2. SNFs must conduct a comprehensive assessment of each beneficiary's needs using the RAI. 42 CFR § 483.20(b).

[12] *RAI Manual 2.0*, § 1.3. At the time of our review, 108 MDS items were used to determine the RUG.

For many of the MDS items, SNFs assess the beneficiary during what is called the look-back period.[13] SNFs report this information on the MDS, which in addition to determining the RUG, is used to develop a care plan for the beneficiary. Several of the MDS items are also reported on CMS's Nursing Home Compare Web site, which provides information about each nursing home to the public.

SNFs must conduct assessments on or about the 5th, 14th, 30th, 60th, and 90th days of a Part A stay, as well as on certain other occasions, to account for changes in the beneficiary's care needs.[14] Accordingly, if a beneficiary has a 100-day Part A stay, he or she will have at least five assessments. For each assessment, the beneficiary may be categorized into a different RUG.

Types of RUGs. Each RUG has a different Medicare per diem payment rate. Medicare groups the RUGs into eight distinct categories.[15] Two categories—Rehabilitation and Rehabilitation Plus Extensive Services—are for beneficiaries who need physical therapy, speech therapy, or occupational therapy, typically after a hip fracture or a stroke. In this report, we refer to the RUGs in the two therapy categories as therapy RUGs. The remaining six categories are for beneficiaries who require little to no therapy. We refer to the RUGs in these categories as nontherapy RUGs. At the time of our review, there were 53 RUGs. See Appendix A for a description of the 53 RUGs.

Medicare Payments for Therapy RUGs. Medicare payment rates for therapy RUGs are typically higher than the rates for nontherapy RUGs. In addition, Medicare typically pays more for higher levels of therapy. The therapy RUGs are divided into five levels: ultrahigh, very high, high, medium, or low. The SNF categorizes each beneficiary into one of the five therapy levels based primarily on the number of minutes of therapy provided during the look-back period.[16] For example, if the beneficiary received 45 minutes of therapy during the look-back period, he or she is categorized into a low-therapy RUG, whereas if the beneficiary received 720 minutes, he or she is categorized into an ultrahigh therapy RUG.

---

[13] The length of the look-back period varies depending upon the MDS item. For example, a 7-day look-back period is used to determine the amount of therapy that was provided, while a 14-day look-back period is used to determine whether dialysis was provided. See CMS, *RAI Manual 2.0*, § 3.3 (the discussion of the look-back period begins on page 3-29).

[14] 42 CFR § 413.343(b) and CMS, *RAI Manual 2.0*, § 2.5.

[15] CMS, *RAI Manual 2.0*, §§ 6.3, 6.4, and 6.6. In FY 2011, CMS revised the eight categories.

[16] CMS, *RAI Manual 2.0*, § 6.6.

Medicare generally pays the most for ultrahigh therapy. See Appendix B for further information on the therapy levels.

Changes to Medicare Payments to SNFs. For FYs 2011 and 2012, CMS made a number of changes to SNF payments. Notably, for FY 2011, CMS increased the number of RUGs from 53 to 66 to allocate payments more accurately.[17] CMS also changed how SNFs account for therapy provided to multiple beneficiaries concurrently or in group settings.[18] Further, SNFs must complete a "change of therapy" assessment when the amount of therapy provided no longer reflects the RUG and an "end of therapy" assessment when therapy has been discontinued for 3 consecutive days.[19] Lastly, in FY 2012, CMS reduced payments to SNFs by approximately $3.9 billion to correct for unintended excessive payments made in FY 2011.[20]

Despite these changes, the payment issues we highlight in this report, which are based on 2009 data, are still relevant to the current system. Notably, CMS still bases SNF payments for therapy RUGs on the amount of therapy SNFs provided during the look-back period.

Documentation for Part A SNF Stays

CMS expects SNFs to document in the medical record the care that a beneficiary needs and receives, as well as how he or she responds to the care received.[21] CMS states, in particular, that good clinical practice requires SNFs to document the number of minutes of therapy provided to a beneficiary.[22] In addition, the medical record should support and be consistent with the MDS.

---

[17] 74 Fed. Reg. 40288, 40338 (Aug. 11, 2009).

[18] In concurrent therapy, the therapist works with two beneficiaries at the same time using different treatments. For this type of therapy, SNFs are now required to allocate half the total therapy minutes to each beneficiary when determining the RUG. See 74 Fed. Reg. at 40315–40319; and CMS, *RAI Manual 3.0*, § 6.6. In group therapy, the therapist works with four beneficiaries at the same time using the same or similar treatments. For this type of therapy, SNFs are now required to allocate a quarter of the total therapy minutes to each beneficiary when determining the RUG. See 76 Fed. Reg. 48486, 48514 (Aug. 8, 2011).

[19] 76 Fed. Reg. at 48517-48526.

[20] 76 Fed. Reg. at 48500.

[21] CMS, *RAI Manual 2.0*, § 1.14. See also *RAI Manual 3.0*, § 1.3.

[22] CMS, *RAI Manual 2.0*, § 1.14. See also *RAI Manual 3.0*, § 1.3, and ch. 3, § O.

CMS Oversight of SNFs

CMS contracts with State Survey and Certification agencies to determine whether SNFs are in compliance with Federal requirements.[23] One of the requirements that surveyors verify is the accuracy of the MDS. Surveyors cite facilities for deficiencies if they do not comply with requirements, which may affect their participation in Medicare.[24]

In addition, CMS relies on various contractors to identify, prevent, and reduce fraud, waste, and abuse for Medicare Part A payments, including SNF payments. Medicare Administrative Contractors (MAC) are responsible for processing and paying Part A claims. At their discretion, these contractors may conduct targeted medical reviews of SNF claims to prevent improper payments.[25] Other contractors overseeing SNFs include Recovery Audit Contractors (RAC), which identify and recoup any overpayments made to SNFs, and Zone Program Integrity Contractors and Program Safeguard Contractors, which identify fraud and abuse and refer cases to law enforcement, when appropriate.

Lastly, CMS monitors the accuracy of payments made to providers through the Comprehensive Error Rate Testing (CERT) program. The CERT contractor reviews a sample of claims to determine an error rate. CMS defines the error rate as the percentage of total dollars that Medicare erroneously paid or denied. For FY 2010, the error rate for inpatient SNF services was 3.3 percent.[26]

Related Reports

The first study in this series found that from 2006 to 2008, SNFs increasingly billed for higher paying RUGs, even though beneficiary characteristics remained largely unchanged.[27] Additionally, for-profit SNFs were far more likely to bill for higher paying RUGs. Furthermore, 348 SNFs had questionable billing, indicating that certain SNFs may be routinely placing beneficiaries into higher paying RUGs regardless of the

---

[23] CMS, *State Operations Manual*, Pub. No. 100-07, ch. 1, § 1010, rev. 1, issued May 21, 2004.

[24] 42 CFR § 488.330.

[25] CMS provides guidance to MACs on how to conduct medical reviews of SNF claims. See *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 6, § 6.1.3, rev. 196, issued March 30, 2007.

[26] CMS, *The Supplementary Appendices for the Medicare Fee-for-Service 2010 Improper Payment Report*, p.10. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/CERT/Downloads/Supplementary-Appendices-for-the-Medicare-Fee-for-Service-2010-Improper-Payment-Report.pdf on June 28, 2012.

[27] OIG, *Questionable Billing in Skilled Nursing Facilities*, OEI-02-09-00202, December 2010.

beneficiaries' care and resource needs. OIG recommended that CMS (1) monitor overall payments to SNFs and adjust rates, if necessary; (2) change the current method for determining how much therapy is needed to ensure appropriate payments; (3) strengthen monitoring of SNFs that are billing for higher paying RUGs; and (4) follow up on the SNFs identified as having questionable billing. CMS concurred with all of the recommendations but the second one, noting concerns about relying on information from the beneficiary's hospital stay to determine the beneficiary's therapy needs.

Another OIG study found that despite changes to the SNF payment system in FY 2011 that were meant to be budget neutral, Medicare payments increased by $2.1 billion, or 16 percent, from the last half of FY 2010 to the first half of FY 2011.[28] Contrary to CMS's expectations, in the first half of FY 2011, SNFs billed for higher levels of therapy, which contributed to the overall increase in payments. The data indicated that CMS should adjust payment rates to address the significant increases in payments to SNFs. As noted earlier, in FY 2012, CMS reduced payments to SNFs by approximately $3.9 billion.

METHODOLOGY

We based this study on a medical record review of a random sample of Part A SNF claims from calendar year 2009.

Selection of Sample for Medical Review

Using CMS's National Claims History File, we first identified all Part A SNF claims with a service date in 2009.[29] We grouped these claims by stay using the admission date and identified the stays that ended in 2009. We then grouped these stays into three strata defined by the length of the stay and the number of claims. We selected a stratified simple random sample of 245 stays and then selected 499 claims from these stays.[30] These claims project to the 6,445,273 claims in the population. See Appendix C for more information about how we selected the stays and the claims.

[28] OIG, *Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011*, OEI-02-09-00204, July 2011.

[29] In this report, we refer to claim line items as claims.

[30] We stratified the sample in this way to meet the objectives of this study and our companion study, *Medicare Requirements for Quality of Care in Skilled Nursing Facilities*, OEI-02-09-00201, forthcoming.

Medical Record Review

We used a contractor to collect and review the medical records for each sampled claim. The contractor made up to five attempts to obtain the medical records. We had a 100-percent response rate.

We also contracted with medical record reviewers. The reviewers consisted of three registered nurses, each of whom had at least 12 years of SNF experience, and a physical therapist, an occupational therapist, and a speech therapist. The nurses reviewed the records and consulted with the therapists as needed. The reviewers used a standardized data collection instrument that was based on Medicare coverage requirements, CMS guidance for completing the MDS, and CMS guidance to MACs for reviewing SNF claims. The instrument was developed in collaboration with the reviewers and tested on a separate sample of claims.[31] The reviewers conducted the medical review between April and September 2011.

The reviewers determined whether each claim met Medicare coverage requirements that (1) the SNF stay be related to a condition that was treated in the prior hospital stay, (2) the beneficiary needs and receives daily skilled nursing or therapy, and (3) the beneficiary has a physician order for skilled nursing or therapy. If the beneficiary became ineligible for SNF care at some point during the stay, the reviewers indicated approximately when the stay should have ended. In this report, we refer to this group of claims as not meeting Medicare coverage requirements.

If a claim met the requirements above, the reviewers then focused on the MDS items used to determine the RUGs. For each MDS item, the reviewers determined whether the information reported by the SNFs for the item was supported and consistent with the medical record. If an MDS item was inaccurate, the reviewers recoded the item on the basis of their review of the medical record.

For the MDS items related to therapy, the reviewers looked in the medical record for the number of days and minutes of therapy provided to the beneficiary during the look-back period and compared them to those recorded on the MDS. The reviewers noted any inconsistencies and recoded the MDS on the basis of their review of the medical record. They also determined whether the therapy provided during the look-back period

[31] We conducted a preliminary review of 25 claims to test the instrument and to ensure consistency among the reviewers.

was reasonable and necessary.[32] For those claims in which they determined that a portion of the therapy was not reasonable and necessary, they estimated the amount of therapy that was reasonable and necessary and recoded the MDS items. In addition, the reviewers noted any inconsistencies between the amount of therapy provided during and after the look-back period.[33]

Analysis

We analyzed the information from the medical review to determine the percentage of claims SNFs billed in error and the amount Medicare inappropriately paid for them. To do this, we first determined the number and percentage of claims that did not meet Medicare coverage requirements. We projected this percentage to the population of Part A SNF claims for stays that ended in 2009.

For the remaining claims, we generated a revised RUG for each claim on the basis of the recoded MDS data from the medical reviewers. We used CMS's SAS program to generate the revised RUG.[34] If the original RUG was a higher paying RUG than the revised RUG, we considered the claim to be upcoded. Conversely, if the original RUG was a lower paying RUG than the revised RUG, we considered the claim to be downcoded. We calculated the overall percentage of claims that were inaccurate (i.e., upcoded or downcoded) and projected this rate to the population of Part A SNF claims for stays that ended in 2009.

Next, we determined the total amount Medicare inappropriately paid for SNF claims. For the claims that did not meet Medicare coverage requirements, we calculated the amount that Medicare paid inappropriately by multiplying the payment rate by the number of days that did not meet Medicare coverage requirements. For the claims with inaccurate RUGs, we determined the net difference between the amount that was paid and the amount that should have been paid. We added this to the amount that Medicare inappropriately paid for claims that did not

---

[32] This is consistent with CMS's instructions to the MACs for reviewing SNF claims. CMS instructs medical reviewers to determine whether the services indicated on the MDS were rendered and were reasonable and necessary. If the reviewer determines that some services provided were not reasonable and necessary or were not supported in the medical record, the reviewer enters the correct data and calculates the RUG. The MAC then pays the claim according to the revised RUG. See *Medicare Program Integrity Manual*, ch. 6, § 6.1.3, rev. 196, issued March 30, 2007.

[33] The reviewers did not recode the MDS on the basis of this analysis.

[34] We generated a RUG for each claim except in two instances. For two claims, the SNF billed the default payment rate, which we considered to be appropriate on the basis of Medicare policy. SNFs receive the default rate if they do not submit the MDS to Medicare in accordance with the assessment schedule.

meet Medicare coverage requirements and projected it to the population of all Part A SNF claims for stays that ended in 2009.

Lastly, we analyzed the extent to which SNFs misreported information on the MDS for items that affect SNF payment.[35] For each category of MDS items established by CMS, we calculated the percentage of claims associated with inaccurate MDS information.[36] We also calculated the overall percentage of claims associated with one or more inaccurate MDS items. We projected the results to the population of all Part A SNF claims for stays that ended in 2009.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

[35] This analysis did not include the 12 claims that did not meet Medicare coverage requirements for the entire claim period or that were billed at the default rate.

[36] The categories of MDS items are listed in the *RAI Manual 2.0*, ch. 3.

FINDINGS

SNFs billed one-quarter of claims in error in 2009, resulting in $1.5 billion in inappropriate Medicare payments

On the basis of our medical record review, we found that SNFs billed an estimated 25 percent of claims in error in 2009. Medicare inappropriately paid $1.5 billion for these claims. This represents 5.6 percent of the $26.9 billion paid to SNFs in 2009. See Table 1 for the percentage of SNF claims that were in error and Appendix D for the confidence intervals.

Table 1: Percentage of SNF Claims That Were in Error, 2009

Type of Error	Percentage of SNF Claims
Inaccurate RUGs	**22.8%**
Upcoded	20.3%
Downcoded	2.5%
Did Not Meet Coverage Requirements	**2.1%**
Total error rate	**24.9%**

Source: OIG analysis of medical record review results, 2012.

SNFs billed inaccurate RUGs in 23 percent of claims

As noted earlier, SNFs use the MDS to assess beneficiaries and classify them into RUGs. Each RUG is associated with a different payment rate. SNFs billed inaccurate RUGs in 23 percent of claims. Most of these claims were upcoded; far fewer were downcoded. Claims with inaccurate RUGs amounted to a net $1.2 billion in inappropriate Medicare payments.

Notably, 20 percent of claims billed by SNFs had higher paying RUGs than were appropriate. In these cases, the SNFs upcoded the RUGs on the claims. For approximately half of these claims, SNFs billed for ultrahigh therapy RUGs when they should have billed for lower levels of therapy or nontherapy RUGs.[37]

For 57 percent of the upcoded claims, SNFs reported providing more therapy on the MDS than was indicated in the medical record. For a quarter of the upcoded claims, reviewers determined that the amount of therapy indicated in the beneficiaries' medical records was not reasonable

[37] The point estimate is 48 percent with a 95-percent confidence interval of 35 to 62 percent.

and necessary. For example, in one case, the SNF provided the highest level of therapy to the beneficiary even though the medical record indicated that the physician refused to sign the order for therapy. In another example, the SNF provided an excessive amount of therapy to the beneficiary given her condition. In another example, the SNF reported on the MDS that speech therapy was provided even though the record contained an evaluation of the beneficiary concluding that no speech therapy was needed and that speech therapy had not been provided.

For the upcoded claims, the difference in payments between the RUGs billed by the SNFs and the RUGs supported by the medical records was often quite large. In many instances, it amounted to over $100 per day, and in one case, the difference was $414 per day.

The remaining 3 percent of claims had lower paying RUGs than were appropriate. In these cases, the SNFs downcoded the RUGs on the claims. The difference in payments between the RUGs billed by the SNFs and the RUGs supported by the medical records was typically less than $100 per day. In the most extreme case, the difference amounted to $166 per day.

Two percent of SNF claims did not meet Medicare coverage requirements

A smaller percentage of claims did not meet Medicare coverage requirements. For some of these claims, beneficiaries were not eligible for SNF care, either because they did not need skilled nursing or therapy on a daily basis or because there were no physician orders for these services. For the remaining claims, the beneficiaries became ineligible for SNF care at some point during the claim period because they no longer needed or received skilled nursing or therapy on a daily basis.

SNFs misreported information on the MDS for 47 percent of claims

SNFs reported inaccurate information, which was not supported or consistent with the medical record, on at least one MDS item for 47 percent of claims. SNFs use the MDS to assess each beneficiary's clinical condition, functional status, and expected and actual use of services. Certain items on the MDS are used to determine the RUG; therefore, misreporting information for these items can lead to inaccurate RUGs and inappropriate payments.[38] SNFs also use the MDS to develop care plans for each beneficiary, so inaccurate information on the MDS can affect care. In addition, several MDS items are reported on CMS's

[38] Inaccuracies in the MDS items do not always result in a change in the RUG.

Nursing Home Compare Web site, which provides information to the public about each nursing home.

For 30 percent of claims, SNFs misreported the amount of therapy that the beneficiaries received or needed. As noted earlier, the amount of therapy that SNFs report on the MDS largely determines the RUG and Medicare payments to SNFs. See Table 2 for MDS categories with misreported information and Appendix E for additional categories and the confidence intervals.

Table 2: MDS Categories With Misreported Information

MDS Category With Misreported Information	Percentage of Claims
Therapy (i.e., physical, occupational, speech)	30.3%
Special Care (e.g., intravenous medication, tracheostomy care)	16.8%
Activities of Daily Living (e.g., bed mobility, eating)	6.5%
Oral/Nutritional Status (e.g., parenteral feeding)	4.8%
Skin Conditions and Treatments (e.g., ulcers, wound dressings)	2.4%

Source: OIG medical record review, 2012.
Note: The rows do not sum to 47 percent because some claims had more than one problem.

In addition, reviewers found several instances in which SNFs provided more therapy during the look-back period than they did during periods that did not determine payment rates. In one example, the SNF provided 90 to 110 minutes of therapy a day to the beneficiary during the look-back period; however, after that period, the SNF provided only about half that amount of therapy to the beneficiary. In another example, the SNF provided 50 to 55 minutes of therapy a day to the beneficiary during the look-back period. It lowered the amount to 30 to 40 minutes a day during the rest of the coverage period but then raised it back to 50 to 55 minutes during the next look-back period.

For 17 percent of claims, SNFs misreported whether the beneficiaries received special care. The inaccuracies came primarily from one MDS item in this category—intravenous medication. At the time of our review, SNFs were allowed to report intravenous medication if the beneficiary received it in the hospital prior to or during the SNF stay. For these claims, the medical records either did not indicate that intravenous

medication was provided during the hospital or SNF stay or clearly contradicted that these services were provided.[39]

For 7 percent of claims, SNFs misreported the amount of assistance beneficiaries needed with activities of daily living (e.g., bed mobility, transfers, eating, and toilet use). Beneficiaries who need high levels of assistance may be placed into higher paying RUGs. In several cases, SNFs reported on the MDS that beneficiaries needed more assistance than was indicated in the medical record. For example, one SNF reported that a beneficiary needed extensive assistance with transferring between two locations, such as from a bed to a chair; however, the medical record noted that the beneficiary was able to do this independently.

SNFs also misreported MDS items related to oral and nutritional status and items related to skin conditions and treatments. Notably, for the items related to skin conditions and treatments, SNFs did not always report the correct number or stage of skin ulcers or they reported the presence of burns or open lesions inaccurately. They also did not always correctly report skin treatments, such as surgical wound care or ulcer care.

[39] In FY 2011, CMS changed the rules about reporting intravenous medication on the MDS; it no longer allowed SNFs to report whether it was provided during the prior hospital stay. It also revised the RUGs so that reporting this item no longer placed the beneficiary into a higher paying RUG.

CONCLUSION AND RECOMMENDATIONS

SNFs billed one-quarter of claims in error in 2009, resulting in $1.5 billion in inappropriate Medicare payments. The majority of the claims in error were upcoded; many of these were for ultrahigh therapy. The remaining claims in error were downcoded or did not meet Medicare coverage requirements. In addition, SNFs misreported information on the MDS for 47 percent of claims. SNFs commonly misreported the amount of therapy the beneficiary received or needed, which largely determines how much Medicare pays the SNF.

We recognize that CMS has made several significant changes to SNF payments for FYs 2011 and 2012. However, more needs to be done to reduce inappropriate payments to SNFs. Given the findings of this report and our prior report, further actions are needed to deter SNFs from billing inappropriately and to prevent Medicare from paying for these claims. Considering the high cost of SNF services, substantial savings to the Government could result if CMS focused additional attention on these payments.

Therefore, we recommend that CMS:

Increase and Expand Reviews of SNF Claims

CMS should instruct its contractors to conduct more medical reviews of SNF claims. CMS should also expand the scope of these medical reviews to more closely scrutinize the MDS items that SNFs commonly misreport. As part of these efforts, contractors should identify SNFs or SNF chains with recurring problems. They should target these SNFs in their reviews and possibly refer them for further investigation, depending upon the nature of the issues. These efforts will help to ensure that SNF payments are accurate and that SNFs are reporting information on the MDS correctly.

Use Its Fraud Prevention System To Identify SNFs That Are Billing for Higher Paying RUGs

Our current report provides further evidence that some SNFs are incorrectly reporting certain MDS items, such as therapy and activities of daily living, to place beneficiaries into higher paying RUGs. CMS should use its Fraud Prevention System to identify and target these SNFs. Specifically, CMS should target SNFs that have a high percentage of claims for ultrahigh therapy and for high levels of assistance with activities of daily living.

Monitor Compliance With the New Therapy Assessments

As of October 2011, SNFs must complete a "change of therapy" assessment when the amount of therapy provided no longer reflects the RUG and an "end of therapy" assessment when therapy is discontinued for 3 days. Under this new policy, SNFs are paid less when a beneficiary's need for therapy decreases or ends. This policy helps to align payments for therapy to beneficiaries' needs and reduces the incentive to provide substantially more therapy during the look-back period than during periods that do not determine payment rates. However, the success of this policy relies on SNFs' completing the new assessments appropriately.

CMS should instruct its MACs and RACs to closely monitor SNFs' utilization of these assessments through analyses of claims data. Such analyses will identify SNFs that are using the assessments infrequently or not at all. The MACs and RACs should then target these SNFs for review to establish whether therapy assessments are being completed, as required.

Change the Current Method for Determining How Much Therapy Is Needed To Ensure Appropriate Payments

The findings of this report provide further evidence that CMS needs to change how it pays for therapy. Currently, the amount of therapy that a SNF provides to the beneficiary during the look-back period largely determines the amount that Medicare pays the SNF. This method creates incentives for SNFs to provide and bill for high levels of therapy when these levels may not be needed.

We are aware that CMS is considering two alternative approaches for determining how it pays for therapy. In the first option, CMS is considering basing payment for therapy RUGs on patient need, by using patient diagnoses and service needs to predict the appropriate level of therapy. In the second option, CMS would also predict the appropriate level of therapy but would then reconcile payments after the services have been provided. While our review does not provide information about which method is more appropriate, it does show that CMS needs to change how it pays for therapy to reduce the incentives for SNFs to provide more therapy than necessary and to better align payments to beneficiaries' needs.

Improve the Accuracy of MDS Items

CMS should increase its efforts to ensure that SNFs are completing the MDS accurately. This is critical to ensuring that SNF payments are

accurate and that beneficiaries are assessed and cared for appropriately. It is also essential because several MDS items are published on CMS's Nursing Home Compare Web site, which provides information to the public about each nursing home.

Specifically, CMS should instruct the nursing home surveyors to more closely monitor the accuracy of the MDS. Surveyors should particularly focus on the categories of MDS items that we identified as problematic and cite facilities for deficiencies when necessary. Additionally, CMS should instruct the MACs to provide education to all SNFs, as well as specific training to selected SNFs, to improve the accuracy of their MDS reporting.

Follow up on the SNFs That Billed in Error

In a separate memorandum, we will refer to CMS for appropriate action the SNFs with claims in our sample that had inaccurate RUGs or that did not meet coverage requirements.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CMS concurred with all six of our recommendations. CMS stated that it has taken and continues to take proactive steps to reduce inaccurate, medically unnecessary, and fraudulent claims by SNFs.

CMS concurred with our first recommendation and stated that it will issue a Technical Assistance Letter to the MACs with a link to the OIG report. If the MACs choose to increase and expand their review of SNFs, CMS will ask that they more closely scrutinize the MDS items most commonly misreported and identify specific SNFs or SNF chains with reoccurring issues and focus their reviews on them. In addition, in August 2012, CMS issued a Comparative Billing Report targeted to 5,000 SNFs to help them identify potential errors in their billing practices and make changes to prevent improper billing and payment in the future.

CMS concurred with our second recommendation. It stated that it is committed to building reliable models in the Fraud Prevention System that can detect and generate alerts for suspicious billing behavior and it is currently developing a SNF Model that examines claims data.

CMS concurred with our third recommendation and stated that it is conducting internal monitoring activities related to SNF utilization and provider reaction to the FY 2012 PPS final rule policies. As part of this monitoring, it is analyzing the number of 'change of therapy' assessments that are being completed. In addition, it will conduct further monitoring activities, including analyses by provider type and the provision of therapy by patient risk scores.

CMS concurred with our fourth recommendation and stated that it plans to research alternative SNF payment approaches for therapy and eventually develop an implementable model to account for therapy furnished in SNFs.

CMS concurred with our fifth recommendation and stated that it will convene a meeting with surveyors representing several States and all 10 regions to discuss the onsite survey process and how to improve its effectiveness with investigating MDS items. CMS also noted that it has recently clarified guidance related to surveyor citation of MDS assessments and continues to review those and related guidance. It also plans to conduct additional surveyor training related to the MDS.

CMS concurred with our sixth recommendation and will review the data provided by OIG and take appropriate actions consistent with the agency's policies.

We support CMS's efforts to address these issues. For the full text of CMS's comments, see Appendix F.

APPENDIX A

Description of the 53 Resource Utilization Groups* in Effect During Our Review Period

RUG Category	RUG	Therapy Level	Per Diem Rate FY2009	Per Diem Rate FY2010
Therapy RUGs				
Rehabilitation Plus Extensive Services	RUX	Ultrahigh	$623	$617
	RUL	Ultrahigh	$547	$546
	RVX	Very high	$472	$468
	RVL	Very high	$440	$437
	RHX	High	$400	$396
	RHL	High	$393	$386
	RMX	Medium	$458	$449
	RML	Medium	$420	$413
	RLX	Low	$325	$319
Rehabilitation	RUC	Ultrahigh	$529	$529
	RUB	Ultrahigh	$485	$485
	RUA	Ultrahigh	$462	$463
	RVC	Very high	$425	$421
	RVB	Very high	$404	$401
	RVA	Very high	$363	$364
	RHC	High	$370	$365
	RHB	High	$353	$349
	RHA	High	$328	$326
	RMC	Medium	$340	$335
	RMB	Medium	$331	$326
	RMA	Medium	$323	$320
	RLB	Low	$300	$294
	RLA	Low	$256	$252
Nontherapy RUGs				
Extensive Services	SE3		$375	$362
	SE2		$319	$309
	SE1		$284	$276
Special Care	SSC		$279	$272
	SSB		$264	$258
	SSA		$259	$253
Clinically Complex	CC2		$278	$270
	CC1		$253	$248
	CB2		$241	$236
	CB1		$231	$225
	CA2		$229	$223
	CA1		$214	$211

* RUG.

Continued on next page.

APPENDIX A (CONTINUED)

Description of the 53 Resource Utilization Groups* in Effect During Our Review Period

RUG Category	RUG	Therapy Level	Per Diem Rate FY 2009	Per Diem Rate FY 2010
Nontherapy RUGs (continued)				
Reduced Physical Function	PE2		$221	$217
	PE1		$217	$214
	PD2		$211	$206
	PD1		$208	$203
	PC2		$200	$197
	PC1		$197	$196
	PB2		$176	$175
	PB1		$174	$172
	PA2		$173	$171
	PA1		$168	$166
Impaired Cognition	IB2		$205	$202
	IB1		$202	$199
	IA2		$185	$183
	IA1		$177	$177
Behavior Problems	BB2		$203	$200
	BB1		$197	$196
	BA2		$184	$182
	BA1		$171	$169

Source: 73 Fed. Reg. 46424–26 (Aug. 8, 2008); 74 Fed. Reg. 40298–300 (Aug. 11, 2009). The amounts are based on unadjusted urban rates. There is an urban and a rural payment rate for each RUG. The urban payment rate is lower than the rural rate for the therapy RUGs.

*RUG.

APPENDIX B

Therapy Minutes Received by Therapy Level

Therapy Level	Therapy Minutes Received During the Look-Back Period
Ultrahigh	720 or more
Very High	500–719
High	325–499
Medium	150–324
Low	45–149

Source: Centers for Medicare & Medicaid Services, *Resident Assessment Instrument Manual (RAI) Version 2.0*, ch. 6. See also *RAI Manual Version 3.0*, ch. 6.

APPENDIX C

Sample Design

Stratum	Stratum Description	Number of Stays in the Population	Number of Stays in the Sample	Number of Claims in the Population	Number of Claims in the Sample
1	Length of stay less than 21 days in 2009 and 3 or fewer claims in 2009 We selected all claims from each stay.	1,264,073	55	1,792,685	78
2	Length of stay 21 or more days in 2009 and 3 or fewer claims in 2009 We selected all claims from each stay.	435,893	45	1,133,322	117
3	Stays with over 3 claims in 2009 If the stay had 4 to 7 claims, we randomly selected 2. If the stay had over 7 claims, we randomly selected 40 percent of the claims.	668,799	145	3,519,266	304
Total		**2,368,765**	**245**	**6,445,273**	**499**

Source: Office of Inspector General medical record review, 2012.

APPENDIX D

Sample Sizes, Point Estimates, and 95-Percent Confidence Intervals for Estimates Presented in the Report

Characteristic	Sample Size	Point Estimate	95-Percent Confidence Interval
SNF claims in error in 2009	499	24.9%	19.9%–30.4%
SNF claims with inaccurate RUGs	499	22.8%	18.0%–28.2%
SNF claims with higher paying RUGs than were appropriate (upcoded)	499	20.3%	15.6%–25.6%
Upcoded SNF claims that had an ultrahigh RUG	101	48.2%	34.9%–61.7%
Upcoded SNF claims in which SNFs reported providing more therapy on the MDS than was indicated in the medical record	101	56.8%	42.8%–70.2%
Upcoded SNF claims in which reviewers determined that the amount of therapy was not reasonable and necessary	101	25.6%	14.6%–39.4%
SNF claims with lower paying RUGs than were appropriate (downcoded)	499	2.5%	1.3%–4.5%
SNF claims that did not meet Medicare coverage requirements	499	2.1%	0.7%–4.7%
Total inappropriate Medicare payments for SNF claims	499	$1.5 billion	$988 million–$2.0 billion
Inappropriate Medicare payments in proportion to total payments to SNFs in 2009	499	5.6%	3.7%–7.6%
Medicare payments for SNF claims with inaccurate RUGs	499	$1.2 billion	$736 million–$1.6 billion
SNF claims that had inaccurate information on the MDS	487	47.3%	41.2%–53.5%

Source: Office of Inspector General medical record review, 2012.

APPENDIX E

Point Estimates and 95-Percent Confidence Intervals of Minimum Data Set* Categories With Misreported Information

MDS Category	Point Estimate (n=487)	95-Percent Confidence Interval
Therapy minutes and days for physical, occupational, and speech therapy	30.3%	24.7% – 36.3%
Special care (e.g., intravenous medication, tracheostomy care)	16.8%	12.3% – 22.1%
Activities of daily living (e.g., bed mobility, eating)	6.5%	4.1% – 9.7%
Oral/nutritional status (e.g., parenteral feeding)	4.8%	2.5% – 8.2%
Skin conditions and treatments (e.g., ulcers, wound dressings)	2.4%	1.0% – 4.8%
Nursing rehab/restorative care (e.g., grooming, communication, transfer)	0.8%	0.2% – 2.2%
Continence	0.6%	0.1% – 1.8%
Problem conditions (e.g., fever, delusions, vomiting)	0.6%	0.0% – 2.4%
Disease diagnosis	0.5%	0.0% – 2.0%
Medications	0.2%	0.0% – 1.2%
Physician orders	0.2%	0.0% – 1.0%
Respiratory therapy	0.2%	0.0% – 1.0%
Physician visits	0.1%	0.0% – 1.0%
Cognitive patterns	0.0%	N/A
Communication/hearing patterns	0.0%	N/A
Mood and behavior patterns	0.0%	N/A
Time awake	0.0%	N/A

Source: Office of Inspector General medical record review, 2012.
* MDS

APPENDIX F

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: SEP 2 7 2012

TO: Daniel R. Levinson
Inspector General

/S/

FROM: Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009 (OEI-02-09-00200)

Thank you for the opportunity to review and comment on the OIG draft report titled, "Inappropriate Payments to Skilled Nursing Facilities Cost Medicare More Than a Billion Dollars in 2009," (OEI-02-09-00200). The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG has utilized in reviewing this issue.

The CMS has taken and continues to take proactive steps to reduce inaccurate, medically unnecessary, and fraudulent claims by skilled nursing facilities (SNFs). CMS is committed to identifying and educating SNFs who consistently bill for a high number of services specifically for higher paying resource utilization groups (RUGs). The measures implemented by CMS include issuing a Comparative Billing Report (CBR) focused on SNFs with high therapy utilization, implementing internal monitoring activities related to SNF utilization, and utilizing the Fraud Prevention System to look for aberrant billing practices. These efforts are designed to address the issues the OIG has found over the past few years with billing by SNFs as well as the concerns expressed by the Medicare Payment Advisory Commission regarding SNFs billing improperly for therapy to obtain additional Medicare payments. These initiatives are discussed in greater detail in CMS's responses to the OIG's recommendations.

The findings contained in this report reflect OIG's review of SNF claims from 2009 to determine if the information reported on the Minimum Data Set (MDS) was consistent and supported by documentation in the medical record. The SNFs use the information on the MDS to assign beneficiaries to RUGs. The amount Medicare pays the SNFs is based on the RUG level of a beneficiary. This report is the second in a series of reports about SNF payments and quality of care.

The OIG found that in 2009, one-quarter of all claims billed by SNFs were in error. This resulted in a potential $1.5 billion in inappropriate payments. Upcoding, mainly for ultra-high therapy, was the error seen on the majority of the claims. The other claims were either

downcoded or did not meet coverage requirements. Also, SNFs reported inaccurate information on the MDS on 47 percent of the claims. Therapy was the most common inaccurately reported information. Therapy is a large part of what determines the RUG and, therefore, how much a SNF is paid by Medicare.

The CMS has reviewed the report and has provided the following responses to OIG's recommendations.

OIG Recommendation 1

Increase and expand reviews of SNF claims.

CMS Response

The CMS concurs. CMS will issue a Technical Direction Letter (TDL) to the Medicare administrative contractors (MACs) with a link to the OIG report. CMS will inform the MACs that these findings are informational and will be considered a source of data as they prioritize their work load for medical review, along with all the data they consider. We note that CMS and MACs must balance the respective return on investment of medical review activities focused on SNF services with reviews of other service types. CMS will ask that if the MACs choose to increase and expand their review of SNFs, they more closely scrutinize the MDS items most commonly misreported and identify specific SNFs or SNF chains with reoccurring issues and focus their reviews on them.

In addition, on August 31, 2012, CMS developed and issued a CBR targeted to 5,000 SNFs across the country that consistently billed for a high number of services at the ultra-high therapy RUG level. The CBR is not intended to be punitive nor is it an indicator of fraud. The intent of the CBR is to be proactive and provide SNFs with valuable data and information with respect to their coding and billing practices. The goal of this process is to help SNFs identify potential errors in their billing practices and make changes to prevent improper billing and payment in the future.

OIG Recommendation 2

Use its Fraud Prevention System to identify SNFs that are billing for higher paying RUGs.

CMS Response

The CMS concurs. CMS is committed to building reliable models in the Fraud Prevention System that can detect and generate alerts for suspicious billing behavior by all major provider types, including SNFs. We are currently developing a Skilled Nursing Facility Model that examines claims data to identify aberrant billing practices, as determined by a panel of subject matter experts and data analysis.

OIG Recommendation 3

Monitor compliance with the new therapy assessments.

CMS Response

The CMS concurs with the recommendation to monitor compliance with the new therapy assessments. CMS is conducting internal monitoring activities related to SNF utilization and provider reaction to the fiscal year (FY) 2012 SNF Prospective Payment System (PPS) final rule policies. The changes made in the FY 2012 SNF PPS final rule were designed to pay more accurately for SNF services and include a new therapy assessment type, the Change-of-Therapy (COT) Other Medicare Required Assessment (OMRA). The COT OMRA is required for patients receiving therapy services whenever the intensity of therapy changes to such a degree that it would no longer reflect the RUG-IV classification and payment assigned for the patient based on the most recent assessment used for Medicare payment.

As part of our internal monitoring activities, we are analyzing the number of COT OMRAs completed as part of the SNF PPS. We have completed an analysis of these monitoring activities through the second quarter of FY 2012 and the results can be found at the following website: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/Spotlight.html. The monitoring results show that the COT OMRA comprises roughly 10 percent of the MDS assessment types submitted. Prior to FY 2012, CMS was not able to identify those instances that reflected changes in the intensity of therapy billed compared to what the patient actually received. Therefore, payment accuracy has increased for therapy services in FY 2012 and beyond.

In addition, CMS will conduct further monitoring activities including analyses by provider type (for-profit, non-profit, and government) and provision of therapy services by patient risk scores. This work is currently ongoing.

OIG Recommendation 4

Change the current method for determining how much therapy is needed to ensure appropriate payments.

CMS Response

The CMS concurs with this recommendation. CMS plans to research alternative SNF payment approaches for therapy services and eventually develop an implementable model to account for therapy services furnished in SNFs.

OIG Recommendation 5

Improve the accuracy of MDS items.

CMS Response

The CMS concurs with this recommendation. We plan to address surveyor effectiveness with respect to investigation of MDS issues in a number of ways. First, CMS will convene a 2-day meeting with front line surveyors representing several states and all 10 regions to discuss the on-site survey process and how to improve its effectiveness with investigating MDS items. This discussion will include a review of how surveyors investigate MDS issues and how they focus on specific categories within the MDS. We have recently clarified guidance related to surveyor citation of MDS assessments at F272-276, and continue to review those and related guidance. We also plan to conduct additional surveyor training related to the MDS and care plans, since citations for care plans have also been the focus of other recent OIG reports.

OIG Recommendation 6

Follow up on the SNFs that billed in error.

CMS Response

Once CMS receives the separate memorandum from the OIG detailing the SNF overpayments, CMS will review it and take appropriate actions consistent with the agency's policies.

We appreciate the effort that went into this report and look forward to continuing to work with OIG on safeguarding the Medicare program.

ACKNOWLEDGMENTS

This report was prepared under the direction of Jodi Nudelman, Regional Inspector General for Evaluation and Inspections in the New York regional office, and Nancy Harrison and Meridith Seife, Deputy Regional Inspectors General.

Judy Kellis served as the team leader for this study. Other Office of Evaluation and Inspections staff from the New York regional office who conducted the study include Judy Bartlett. Central office staff who provided support include Kevin Farber, Sandy Khoury, Berivan Demir Neubert, Sue Nonemaker, Debra Roush, and Julie Taitsman.

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.