



Hospice Audit Update

Kelly Grahovac
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Office of Inspector General

OIG Work Plan, Office of Audit Services and Office of Evaluations and Inspections



OIG Work Plan

Project	Posted
Trends and Patterns in Data Related to Newly Enrolled Hospice Providers	4/2025
Audit of Selected, High-Risk Medicare Hospice General Inpatient Services	6/2023
Review of Hospices Compliance with Medicare Requirements	1/2023
Joint work with State Agencies	12/2022



OIG Audit: Trends and Patterns in Data Related to Newly Enrolled Hospice Providers

- Federal requirements state that hospices must be certified by CMS and be licensed as required by State and local law.
- Medicare also requires that hospices meet its Conditions of Participation to receive payment.
- Our objective is to identify trends, patterns, and key comparisons that indicate potential vulnerabilities related to new Medicare hospice provider enrollments. The data brief may help CMS evaluate the need for additional monitoring and program integrity efforts to ensure that hospices meet all the requirements.



OIG Audit: Selected, High-Risk Medicare Hospice General Inpatient Services

- The reimbursement rate for hospice general inpatient (GIP) care is the second-highest daily rate that Medicare pays for hospice services.
- GIP care is provided only for pain control or acute or chronic symptom management that cannot be managed in other settings. It is intended to be short-term care.
- Focus on claims for enrollees who were transferred to GIP care immediately after an inpatient hospital stay for a period during which the enrollee's inpatient stay reached or exceeded the geometric mean length of stay for the assigned diagnosis-related group.
- These hospice GIP claims are at high risk for inappropriate billing because GIP care may exceed an enrollee's needs or may not be provided. We will determine whether hospice providers that billed for GIP care complied with Medicare requirements.





RAC

Recovery Audit Contractor



New Federal RAC Contract

- Performant Recovery lost their contract to Cotiviti
- Performant has ceased auditing and is finishing up reviews, rebuttals, and appeals
- Cotiviti has started auditing
- Experienced Medicaid contractor, but little Medicare
- Contingency fee has not been disclosed publicly



New Federal RAC

- Visit <https://www.cotiviti.com/cms-approved-issues-cotiviti> for list of CMS approved issues for review
- Utilize the provider portal to:
 - Upload discussions and correspondence
 - Download, view and print RAC letters
 - Upload medical records
 - Check your claim review status 24/7
 - Update contact information
 - Export data



RAC Audit Process

- The RAC reviews claims on a post payment basis
- Audit issues must be approved by CMS
- Two types of reviews:
 - Automated (no medical record needed)
 - Complex (medical record required)
- Providers have 45 days to respond, but can request extensions



RAC - Complex

Review Topic	Details	Date Approved	Affected Codes
Hospice Continuous Home Care: Medical Necessity and Documentation Requirements	This review will determine if hospice Continuous Home Care services were reasonable and necessary to achieve palliation and management of the patient's acute medical symptoms to maintain the terminally ill patient at home, based on the documentation in the medical record. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment.	1/5/2021	REV Codes: 0652 HCPCS Codes: G0299, G0300, G0156
Hospice General Inpatient Care: Medical Necessity and Documentation Requirements	This review will determine if Hospice General Inpatient Care (GIP) was reasonable and necessary to achieve pain control or acute or chronic symptom management which could not be managed in any other setting. Claims that do not meet the indications of coverage and/or medical necessity will be <u>recoded to Routine Hospice Care 0651 and result in an overpayment.</u>	8/27/2025	REV Code: 0656 General Inpatient Care
Hospice Care - Extended Length of Stay: Medical Necessity and Documentation Requirements	This review will determine if billed Hospice Care with Extended Lengths of Stay was reasonable and necessary. Claims that do not meet the indications of coverage and/or medical necessity will be denied and result in an overpayment.	8/26/2025	REV Codes <ul style="list-style-type: none"> •0651- Routine Home Care •0652- Continuous Home Care •0655- Inpatient Respite Care •0656- General Inpatient Care

SMRC

Supplemental Medical Review Contractor



Supplemental Medical Review Contractor (SMRC)

- Conducts nationwide medical reviews, as directed by CMS
- Reviews are assigned through CMS and focus on analysis of national claims data issues identified by:
 - Federal agencies - Office of Inspector General (OIG), Government Accountability Office (GAO)
 - CMS internal data analysis
 - Comprehensive Error Rate Testing (CERT) program
- Three types of SMRC Reviews
 - Provider Compliance Group
 - Program Integrity Group
 - Healthcare Fraud Prevention Partnership

SMRC Audit Process

- SMRC reviews claims on a post payment basis
- Affected providers receive an ADR letter
- Providers have 45 days to respond but can request extensions
- Supplier will receive Review Results Letters with detailed findings
 - Agree: Refund upon receipt of overpayment demand
 - Disagree:
 - Request a re-review - opportunity to submit additional documentation for review
 - Appeal upon receipt of overpayment demand



SMRC Current Projects

There are currently no hospice related projects



SMRC Completed Projects

- Project ID 01-099 – Hospice 90 Day Stay
 - Error rate: 16%
 - Non-response rate: 11%
 - The SMRC was tasked to perform data analysis and conduct medical record review activities. The SMRC performed medical record review on Part A hospice claims, specifically the second benefit period, with dates of service (DOS) January 1, 2021, through December 31, 2021.
- Common Reasons for Denial:
 - Medical Documentation Not Received
 - Invalid Election Statement
 - Election Statement Not Received



UPIC

Unified Program Integrity Contractor



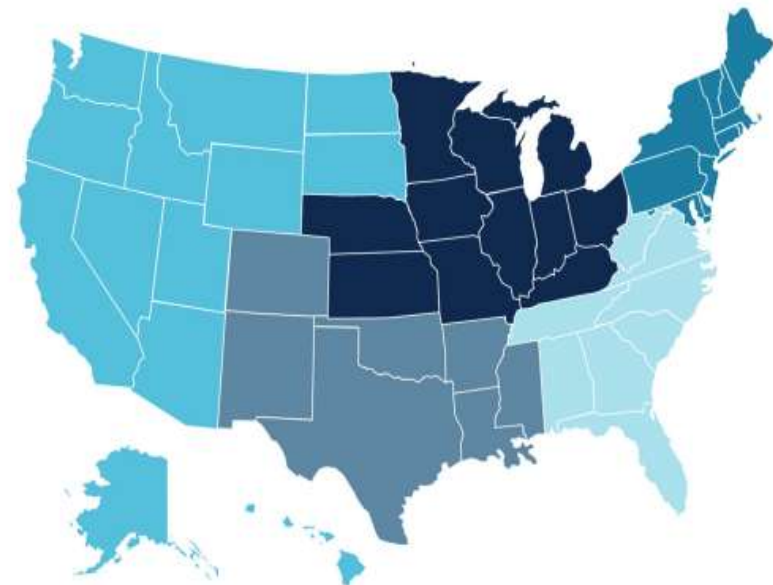
Unified Program Integrity Contractors

- Perform program integrity functions
- Primary goal is to investigate suspected fraud, waste, and abuse
- Share information (leads, vulnerabilities, concepts, approaches) with other UPICs
- Are often very aggressive although CMS oversight has increased in recent years
- Now, UPIC investigations must be approved by CMS Program Integrity Group



UPIC Contracts

- Qlarant Western and Southwest
 - Total Funding = \$115,325,516
- CoventBridge Midwest
 - Total Funding = \$155,389,846
- Safeguard Services Southeast and Northeast
 - Total Funding = \$257,936,858



Current UPIC Audit Trends

- Prepayment audits
 - Rounds similar to TPEs (informal)
- Communication between UPIC Auditors and BFCC QIOs
 - Begins with UPIC audit request, BFCC QIO documentation request to follow



Audits – Looking Ahead

- Things are still uncertain under new Administration, but audit volumes are likely to increase due to focus on fraud, waste and abuse
- Implementing use of technology in audit functions
 - **WISeR** (Wasteful and Inappropriate Service Reduction) Model
- Program Integrity functions will be under some scrutiny and we may see positive changes
- Managed care plans will continue increase audit functions
- CMS scrutiny on provider enrollment functions will expand further in both Medicare and Medicaid



Reducing Fraud, Waste and Abuse



Landscape

- Current administration is fixated on reducing fraud, waste and abuse in Medicare and Medicaid
- That's a good thing, but the administration is unpredictable
- Many of the programs being implemented do not directly impact reducing fraud, waste and abuse but will impact providers.



Why CMS is intensifying focus

- Hospice has been identified as a persistent risk area for improper billing and fraud schemes
- CMS is emphasizing 'detect, stop, and prevent' approaches and greater use of technology
- Providers should expect more scrutiny across audits, enrollment, and quality oversight



Medicaid Fraud

- Administrator Oz [HHS] has applied pressure on states to tighten anti-fraud enforcement
- Governors and state Medicaid leaders were given 10 business days to tell CMS whether they will commit to conducting a swift "revalidation" of high-risk Medicaid providers
- California implemented enrollment moratorium on new hospices



Medicare Fraud

- Provisional Periods of Enhanced Oversight (PPEO) for new hospices in effect for California, Texas, Nevada, Arizona, Georgia, and Ohio
- DOJ launched the West Coast Health Care Fraud Strike Force
 - The model involves the examination of data analytics across technology hubs in California, Arizona and Nevada to identify fraud migration across these regions



Hospice CARE Act

- Reintroduced Hospice Care Accountability, Reform, and Enforcement (Hospice CARE) Act
- Focus on Program Integrity and Payment Reform
- Key Topics include:
 - National enrollment moratorium
 - Ownership and managing control reporting
 - Increased survey frequency
 - Additional audit oversight
 - Revised payment model for routine home care



Artificial Intelligence

- WISeR – Wasteful and Inappropriate Service Reduction Model
 - CMS estimates 25% of healthcare spending is wasteful
 - WISeR will harness enhanced technologies like AI and Machine Learning to streamline the review process for certain items and services that are vulnerable to fraud, waste and abuse
 - Will run from 1/1/2026 – 12/31/2031
- Participants will be AI companies that perform prior authorization services for other payers
 - They will be required to have clinicians with the expertise to conduct medical reviews to validate determinations



WISeR Goals

- Focus healthcare spending on services that will improve patient well-being
- Apply commercial payer prior authorization processes that may be faster, easier and more accurate
- Increase transparency of existing Medicare coverage policy
- De-incentivize and reduce use of medically unnecessary care



WISeR Focus

- Participants will apply their technology to help medical reviewers assess a set of services chosen by CMS that they determined:
 - May pose concerns related to patient safety if delivered inappropriately
 - Have existing publicly available coverage criteria
 - May involve prior reports of fraud, waste and abuse.
- Selected services include:
 - Skin and tissue substitutes
 - Implantable Electrical nerve stimulators
 - Knee arthroscopy for knee osteoarthritis



WISeR Focus

- Excluded services
 - Inpatient-only
 - Emergency Services
 - Services that would pose a threat if substantially delayed



WISeR Initiative

- Impact on Providers
 - Optional for providers to participate
 - If they do not participate, they are subject to post-service/prepayment medical review through the same AI tool
- Model payment
 - AI Participants will be awarded based on the effectiveness of their technology for reducing spending on medically unnecessary or non-covered services
 - Participants will receive a percentage of the reduction in savings that can be attributed to their technology



Model Performance Measures

- Process Quality
 - Number of non-affirmations and favorable appeal decisions
 - Volume of requests processed
- Provider/Supplier and Beneficiary Experience
 - Timeliness of response
 - Clarity of explanation of request determination
- Clinical quality outcomes
 - Use of alternative services
 - Evidence of ongoing urgent need to address the clinical issue



Executive Orders on AI

- January 23, 2025, the Administration released EO 14179, titled “Removing Barriers to American Leadership in Artificial Intelligence”
- February 11, 2025, the Administration released EO 13859, titled “Maintaining American Leadership in Artificial Intelligence”
- July 23, 2025, White House released “Winning the AI Race: America’s AI Action Plan
- CMS AI Playbook (Version 4), documents the agency’s evolving approach to AI adoption and maturity and serves as a guidebook

[\(https://ai.cms.gov/\)](https://ai.cms.gov/)



State Legislation of AI

- Regulatory Patchwork Emerging: Many states are legislating AI use in healthcare – from insurance claim algorithms to clinical decision support
- Key Themes:
 - Banning “AI-only” decisions in care and coverage by payers
 - Patients and regulators must be informed when AI is used
 - Preventing discrimination and requiring quality controls in AI tools
 - Allocating funds for AI initiatives to enhance research, development, and training

Comprehensive Regulations to Uncover Suspicious Healthcare (CRUSH) RFI

- Enhanced identity proofing and ownership requirements
- Preclusion List and MAO enrollment requirements
- CMS is considering shortening claim filing deadline for high-risk items from one year to a 90-to-180-day period.
- Beneficiary contact



Other CRUSH Topics

- Reducing Medicare fraud related to laboratory tests, including genetic and molecular diagnostic tests
- AI in Medicare Advantage coding oversight and hospital billing
- Medicaid and CHIP
- State-specific Medicaid and CHIP questions
- Federally Facilitated Exchange (FFE) and State-Based Exchanges (SBEs)



Tax Fraud Partnership


- On November 25th, 2025, Dr. Oz issued a letter to all 50 states and Washington D.C. encouraging them to partner with CMS to take action against healthcare providers and suppliers who commit healthcare and tax fraud.
- Healthcare providers who bill fraudulent insurance claims often fail to report the associated income on their tax returns, creating a dual-layered crime that drains both federal and state tax systems.
- The idea is this initiative will strengthen state-federal enforcement against fraudulent Medicare providers and suppliers.



Audit Response Strategies



UPIC Audit Response Strategy

- UPICs should be treated very differently and carefully
 - Requests from UPIC should be escalated to upper management/ compliance officer immediately
 - Review request and respond with required documentation to support services were provided and medically necessary
 - Conduct a risk assessment to determine potential financial risk so you can prepare, if necessary
 - Prepare “cover letter” that summarizes the medical record and pertinent policy requirements when necessary
 - Consider engaging counsel and/or audit experts
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General Audit Response Strategies

- Prepare intake staff for incoming ADR requests and establish response process: Non-response adds to error rate
- Review ADR request and corresponding coverage policies to ensure documentation meets criteria
- Consider drafting a “cover letter” that summarizes the records and pertinent policy requirements when the opportunity allows
- If documentation is lacking and an addendum would be sufficient, work to obtain this for submission during the appeals process
 - Addendums are sometimes accepted upon appeal, but not during audit
- Request extensions when needed – only on post-payment reviews



Audit Response Strategies

- Review audit results and utilize discussion periods if possible
 - Allows providers to provide additional information to support the original payment of a claim
 - 30 days to submit request
- Review records for valid signatures and obtain attestations where applicable



Proactive Audit Strategies

- A provider without a compliance program is considered negligent and uncovered compliance issues could result in more severe penalties for providers without a compliance program
- Most important elements:
 - Education and Training
 - Internal Auditing
 - Risk Analysis
 - Policies and Procedures
- Have staff regularly review audit contractor web-sites



Questions and Contact Information

Kelly Grahovac
The van Halem Group
(404) 343-1815
Kelly@vanHalemGroup.com
www.vanHalemGroup.com



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