NEWS & INSIGHTS

OIG highlights latest oversight activities, enforcement actions

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News & Insights

The Office of Inspector General (OIG) released the latest edition of its semiannual report to Congress, which details the agency's oversight activities and enforcement actions between October 1, 2024, and March 31, 2025.

Overall, the OIG's total monetary impact during this reporting period was $16.61 billion. The agency issued a total of 165 actionable recommendations across 78 reports over the six-month period, which could lead to nearly $13 billion in savings if implemented.

The report includes information that HHS can use to address its current top management and performance challenges, which were previously identified by the OIG in a 2024 report. For example, the OIG highlighted its recent audit work to help CMS prevent, reduce, and recover improper payments. The agency determined that Part D paid approximately $465.1 million for drugs for which payment was available under the Part A skilled nursing facility (SNF) benefit between 2018 and 2020. The OIG also found that Medicare may have improperly paid up to $454 million for claims that were not in accordance with the quantity limitation in the Over-the-Counter COVID-19 Test Demonstration, which ran from April 2022 to May 2023.

The report also highlights the OIG's recent work to identify cost-saving opportunities. Notably, the agency discovered that Medicare could have saved roughly $7.7 billion with comparable access for enrollees between 2015 and 2020 if swing bed services at critical access hospitals were reimbursed using skilled nursing facility prospective payment system rates.

The OIG also detailed its findings from several audits of high-risk diagnosis codes that show CMS' risk adjustment program overpaid approximately $13.6 million to three Medicare Advantage Organizations (UCare Minnesota, Blue Care Network of Michigan, and Triple-S Advantage, Inc.) from 2016 to 2019. In a separate audit, the OIG determined that diagnoses reported only on health risk assessments (HRA) and HRA-linked chart reviews generated $7.5 billion in Medicare Advantage risk-adjusted payments for 2023, and $4.2 billion of these payments came from in-home HRAs.

Other topics in the report include payments for opioid use disorder treatment, hospital price transparency compliance, cybersecurity, and more.

***Editor's note**: A version of this article was originally published in* Revenue Integrity Insider*, NAHRI's weekly e-newsletter.*

Related Topics:
Auditing and monitoring, Medicare news

The value of addenda in payer contracts

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The provider manual stipulates the policies and procedures used to collect information about the full scope of the patient's episode of care, all the way from precertification to discharge. However, the same market power that the contract manager exercised in negotiating fair payment rates can be leveraged to modify the insurer's [utilization review] UR requirements. Hospitals can request contract addenda to make changes to these policies, and in the current economy, more hospitals are insisting on terms that are balanced and fair. Note, however, that it is not feasible to amend the provider manual, which is typically a generic document applicable to hospital markets across the country.

Contract negotiations can make or break a hospital, because in addition to setting the price list for services provided to the insurer's members, the negotiations also affect the resources that the provider expends to comply with the contract terms. These negotiations are critical in a competitive market, with significant implications for the organization, the patients, and the communities served. Facilities have been known to shut their doors because they passively negotiated and accepted whatever rates a payer offered. It's also been well publicized when negotiations result in a standoff and the hospital or payer walks away, leaving communities stranded. Hospital contract managers generally regard payers as being the hospital's bank—payers hold the money and control the processes.

When the contract manager goes into discussions with the payer, their priorities include setting a rate schedule that works for the hospital, crafting contract terms that simplify claims processing, and protecting against arbitrary denials. It is best to approach the process with a win-win attitude—there are plenty of opportunities to fashion contract provisions that benefit both the plan and the provider. Both parties should recognize that the contract must include terms that define the parties' mutual obligations for greater administrative efficiencies, such as the timeliness of payment and improvements in claims processing, and both are expected to walk out of the room having successfully negotiated a contract that allows each to profit. Hospital representatives also look for ways to improve contract language to cover payment for high-cost drugs, new technologies, sophisticated procedures, and medical devices. Note that, although the chief financial officer or contract manager gets knee-deep in financial discussions, it is rare that they discuss the peripheral issues of UR requirements.

No matter who negotiates these commercial insurer contracts for the hospital, they need to have sufficient data to support their position regarding addendum language and to maximize the UR team's results. The negotiator should use objective information on volumes, payer responsiveness, and denial history to support requests for language changes. For example, if there is little history of clinical denials for a particular payer, then language can be added to reduce the frequency of information requests.

***Editor's note**: This article is an excerpt from "The Hospital Guide to Contemporary Utilization Review, Third Edition" by Stefani Daniels, RN, MSNA, CMAC, and Ronald L. Hirsch, MD, FACP, CHCQM, CHRI.*

Related Topics:
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CMS publishes FY 2026 ICD-10-PCS code set, guidelines

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CMS recently published the fiscal year (FY) 2026 ICD-10-PCS code set and *ICD-10-PCS Official Guidelines for Coding and Reporting*. Although CMS made no significant changes to the guidelines, only new examples for the new technology guidelines, the ICD-10-PCS code set includes 156 new codes, 27 deleted codes, and four new tables.

This update brings the FY 2025 ICD-10-PCS code set to a total of 78,986 codes available for discharges occurring from October 1, 2025, through September 30, 2026.

The new codes and tables cover a range of procedures, some of which include the following tabular updates in the Medical and Surgical section:

- New body part characters in table 00P for Removal and table 00W for Revision of substitutes in the dura mater or spinal meninges
- New qualifier character in table 031 for Bypass of innominate artery to an upper artery
- New table for Transfer procedures involving the nasal system
- New table for Bypass procedures involving the larynx
- New approach value in table 0F1 for Bypass of the common bile duct to the duodenum
- New qualifier character in table 0RR for Replacement of left and right shoulder joints
- New qualifier characters in table 0SR for Replacement of left and right knee joints

These additions include ICD-10-PCS codes such as:

- 00W20KZ, Revision of nonautologous tissue substitute in dura mater, open approach
- 03120JY, Bypass of innominate artery to upper artery with synthetic substitute, open approach
- 09XL0Z3, Transfer of nasal turbinate to sphenoid bone, open approach
- 0C1S3E4, Bypass of larynx to cutaneous with endotracheal airway, percutaneous approach
- 0F198D3, Bypass of common bile duct to duodenum with intraluminal device, via natural or artificial opening endoscopic
- 0RRJ008 Replacement of right shoulder joint with reverse ball and socket synthetic substitute, subscapularis-sparing technique, open approach
- 0SRD07D, Replacement of left knee joint with autologous tissue substitute, medial meniscus, open approach

Some tables only have one new code, including tables 00H for Insertion into the central nervous system and cranial nerves, 02U for Supplement of heart and great vessels, 04U for Supplement of lower arteries, 64A for Hypothermia of physiological systems, and 8E0 for Other Procedures of physiological systems and anatomical regions.

All 27 deletions occur in new technology tables X2A for Assistance of the cardiovascular system, XW0 for Introduction to anatomical regions, and XXE for Measurement of physiological systems. Ninety new codes fall under 17 new technology tables, of which two are new tables for procedures using new technologies for the Inspection of the gastrointestinal system and Insertion into subcutaneous tissue and fascia. For example:

- XDJ07LB, Inspection of upper intestinal tract using ingestible capsule with light absorption sensor, via natural or artificial opening, new technology group 11
- XHH80HB, Insertion of ultrasound transmitter and battery for endocardiac pacing electrode into chest subcutaneous tissue and fascia, open approach, new technology group 11

To view the FY 2026 code set and guidelines in their entirety, visit the CMS website. Coders can also find the full list of code additions, revisions, and deletions on the CMS website by downloading the order addenda in the 2026 ICD-10-PCS Order File (Long and Abbreviated Titles) (ZIP) file.

Editor's note: *This article originally appeared on JustCoding.*

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Coding, Medicare news

Report: AI’s impact on revenue cycle management

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Artificial intelligence (AI) innovations are proving effective in enhancing efficiency, accuracy, and financial performance across the revenue cycle.

Turning potential into performance: AI in revenue cycle management

As AI’s role in revenue cycle management rapidly evolves, healthcare leaders face increasing scrutiny to prove its value. Yet AI is already delivering powerful results to maximize efficiency, enhance accuracy, and accelerate payments.

In a commissioned study conducted by Forrester Consulting on behalf of Waystar, explore the current state of AI adoption across the revenue cycle—and what’s needed to turn potential into measurable performance. Discover where AI is delivering impact and how to unlock true value at scale.

Click here to download the full report and gain insights on the following:

- How—and where—AI is driving meaningful results across revenue cycle operations
- Why growing trust in AI is accelerating adoption among top healthcare organizations
- Where healthcare leaders are planning to expand and refine AI investments

Related Topics:
Auditing and monitoring, Denials and appeals

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