NEWS & INSIGHTS

OIG releases MA compliance program guidance

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News & Insights

After releasing its General Compliance Program Guidance in 2023, the Office of Inspector General (OIG) is continuing to deliver supplemental guides geared toward specific subsectors of the healthcare industry. Released on February 3, the Medicare Advantage (MA) Industry Segment-Specific Compliance Program Guidance (ICPG) details several key risk areas relevant to the MA program and provides recommendations to various parties to mitigate these risks.

This ICPG is the first update that the OIG has made to this category of guidance since 1999. The agency decided to revisit this guidance in response to the growing popularity of managed care and its recent findings related to the MA program. While the ICPG primarily provides instructions to MA Organizations (MAO), it also offers insights to healthcare facilities and other entities engaged with the program.

The ICPG highlights the following key ongoing risk areas that require action from MAOs and other parties:

- Access to care
- Marketing and enrollment
- Risk adjustment
- Quality of care
- Oversight of third parties
- Compliance programs within vertically integrated organizations and other ownership structures
- Submission of accurate claims

Revenue cycle professionals should take note of the OIG's emphasis on risk adjustment. In recent years, the agency's audits have revealed problematic behaviors from MAOs, providers, and others involved in the risk adjustment process. This includes healthcare organizations submitting diagnoses that were not supported by the medical record to inflate MAO payments made under risk-sharing or other arrangements, as well as conducting in-home health risk assessments to generate additional unsupported diagnoses. The OIG encouraged MAOs to implement additional oversight of the risk adjustment process, so facilities should prepare for additional record requests and audits in the future.

Healthcare organizations should also consider the OIG's focus on third-party oversight. The agency urged MAOs to consider implementing tailored compliance processes for healthcare providers that serve as first tier, downstream, or related entities (FDR). For example, if a plan delegates functions to an FDR (e.g., an independent practice association), it can establish an oversight team to monitor the provider and require reports. In this instance, the MAO's oversight efforts could include network adequacy, quality data and analytics, coding audits, and utilization management case logs.

Overall, the ICPG calls on MAOs to increase their voluntary monitoring efforts and go beyond standard compliance program requirements from CMS. As the OIG continues to apply pressure to MA plans, facilities must ensure their internal processes and procedures are sound ahead of potential oversight and compliance policy enhancements.

Revenue cycle professionals can view the complete guidance document to learn more about the seven risk areas for the MA program, as well as access relevant links and resources to assist with compliance efforts. The OIG noted that it may update the ICPG periodically to address new risk areas and compliance measures.

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

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Q&A: AI hallucinations in healthcare

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Q: What are artificial intelligence (AI) hallucinations, and why do they occur?

A: AI hallucinations refer to instances where an AI system produces inaccurate or invented content without any basis in the source data. For example, an AI tool might cite a clinical guideline that doesn't exist or misinterpret a provider's documentation when composing an appeal letter. AI tools can even hallucinate while citing legitimate sources. While these errors may appear minor, they can have significant consequences in the highly regulated world of healthcare reimbursement.

AI hallucinations occur because the large language models that power these tools generate text by predicting patterns based on vast amounts of training data—not by fact-checking against authoritative sources. AI does not "understand" the information it ingests; it merely uses the data to predict the word that statistically is most likely to come next. When the model encounters gaps in context or ambiguous prompts, it may "fill in the blanks" with plausible-sounding but incorrect information.

In healthcare settings, security restrictions can amplify this issue. Many organizations block external AI tools or limit access to real-time clinical databases to comply with HIPAA and cybersecurity policies. This means the AI often works with incomplete or outdated context, increasing the likelihood of hallucinations. In short, some hallucinations may stem not only from the model's design, but also from restricted data environments created for patient privacy and security.

Essentially, hallucinations are a byproduct of how generative AI works—it prioritizes linguistic coherence over factual accuracy. This makes human validation essential, especially in compliance-driven fields like healthcare.

Editor's note: *This Q&A was excerpted from "Trust but verify: The hidden risk of AI hallucinations in appeals," a* CDI Journal *article written by* ***Karen R. Lane, MSN.ed, CCDS, CCDS-O, CDIP, RN****. Opinions expressed are those of the author and do not necessarily reflect those of ACDIS, HCPro, or any of its subsidiaries.*

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April 2026 NCCI edit files now available

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CMS published the latest edition of the National Correct Coding Initiative (NCCI) quarterly edit files, which take effect on April 1. Revenue cycle professionals can download the files on the procedure-to-procedure (PTP) edits, medically unlikely edits (MUE), and add-on code edits web pages.

The 3,750-plus new PTP code pairs are, in part, offset by more than 4,800 deleted code bundles. Most of the new code pairs correspond with medicine codes (U codes) and Category III codes (T codes). Six code pairs have been revised.

The NCCI version 32.1 edits also introduce 121 new MUEs and seven revised MUE counts. The MUE file signifies the cap on daily units of service that providers are eligible to report. Effective April 1, providers will be limited to reporting one unit of service for code **G0447** (Face-to-face behavioral counseling for obesity, 15 minutes) per date of service, which is a reduction of the two units of service currently available.

***Editor's note**: This article includes reporting from Part B News.*

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AHA: Hospitals’ total expenses, patient volumes rose in 2025

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Amid patient volume increases, wage pressure, and increased drug spending, hospitals’ total spending rose by 7.5% last year, according to data shared in the American Hospital Association’s (AHA) annual “Costs of Caring” report. This data-driven assessment seeks to identify the structural drivers of cost increases, instead of narrowing in on hospital prices only.

The analysis was based on industrywide benchmark data from Strata Decision Technology and other sources. The year-over-year total saw a 5.6% increase in workforce spending, a 9.9% increase in supplies, and a 13.6% increase in drug spending. These increases are accompanied by an increase in the quantity of care hospitals took on last year, as inpatient volumes rose 5.3% and outpatient volumes grew 9.8%.

Data from previous years (2019–2024) indicated that hospital case-mix index rose by about five percent. This means that hospitals have been treating “sicker, more care-intensive patients” in the buildup of 2025’s spending increases. AHA’s annual member survey data estimated that about 36% of cost growth across the five-year period was linked to volume increases and 19% to patient acuity. The remaining 45% was tied to input expenses, such as staff and supplies.

In 2025, hospital care maintained roughly one-third of the share of the country’s total health spending. Analyses referenced in the study attribute much of the bump to utilization and acuity.

“In other words, despite hospitals facing higher labor and input costs, treating more patients with greater clinical complexity, and maintaining essential, always-on services that communities depend on, they have managed to keep price increases below the increases in their input costs,” the report reads. “However, this mismatch between expenses and revenue leaves hospitals increasingly at risk of being able to maintain the full spectrum of services on which communities rely.”

The report outlined the negative margins hospitals incur on specific service lines, such as behavioral health, burns and wounds, and infectious disease. It also notes that 56.1% of all hospital costs are tied to service lines where the cost to deliver care is higher than reimbursements—and said shortfalls of payment are felt across public and commercial insurers.

The AHA stressed that almost $18 billion was collectively spent by hospitals to overturn claims initially denied by payers. The organization’s most recent annual survey suggests hospitals spent $43 billion in 2025 to collect payments from insurers. Rising costs of labor, supplies, drugs, and administrative duties, as well as the higher rate of sicker patients, pose great challenges for hospitals and health systems.

***Editor’s note**: This article originally appeared in CDI Strategies, ACDIS’ weekly e-newsletter.*

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