Inspired Compliance Seminar

Compliance Updates: OIG, CMS & Enforcement Trends

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Your Presenter



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Beyond her professional roles, Keisha serves on the Board of Directors for an outpatient mental health clinic and contributes to telehealth and compliance committees. She also sits on the HDDH Committee as Chair for the International Society for Telemedicine and eHealth (ISfTeH). She serves on the Advisory Board for The Nurses Pub and the HIM Department at South New Hampshire University (SNHU). A published author, she writes regularly for KW Advanced Consulting and collaborates with AAPC on coding articles and industry updates.

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TODAY

Learning Objectives

- Explain how OIG and CMS roles differ in audits, oversight and enforcement
- Identify what recent OIG audits reveal about Medicare Advantage risk adjustment
- Recognize audit exposure beyond MA: E/M, virtual services, hospitals, hospice
- Build a practical plan to audit, correct and monitor high-risk areas



How to Use Today

Each finding is paired with a teaching point. Use the action plan at the end as your 30-day starting point.

TODAY

Session Agenda

01

The 2026 Landscape

OIG vs. CMS roles and the Work Plan

02

MA & Risk Adjustment

OIG findings, RADV and readiness

03

Other OIG Findings

E/M, virtual care, hospital, hospice

04

CMS Audits

Program audits and new oversight tools

05

Action Plan

Audit, correct, monitor and discuss

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The 2026 Compliance & Enforcement Landscape

Who audits what, and how to read the signals of future scrutiny

SECTION 1 | THE 2026 LANDSCAPE

Enforcement Is at Record Levels

$6.8B

Total False Claims Act recoveries in FY 2025, the highest in FCA history

$5.7B

Of that total came from health care matters

1,297

New qui tam (whistleblower) lawsuits filed in FY 2025, a record

Source: U.S. Department of Justice FY 2025 False Claims Act statistics (announced January 2026)

OIG by the Numbers: Oct 2025 - Mar 2026

$5.56B

Expected recoveries and savings from OIG audits, evaluations and investigations

1,212

Individuals and entities excluded from federal health care programs

317

Criminal actions, plus 287 civil actions, in six months

Source: HHS-OIG Spring 2026 Semiannual Report to Congress (Oct 1, 2025 - Mar 31, 2026)

SECTION 1 | THE 2026 LANDSCAPE

National Health Care Fraud Takedowns

455

Defendants charged in the June 2026 national takedown

$6.5B

In false claims tied to the 2026 takedown schemes

$14.6B

Intended loss in the June 2025 takedown, the largest to date

Sources: Council of the Inspectors General release (June 24, 2026); DOJ press release (June 30, 2025)

OIG vs. CMS: Who Audits What?

OIG (HHS Office of Inspector General)

- Independent oversight of HHS programs
- Audits, evaluations, investigations
- Recommends refunds; refers fraud to DOJ
- Exclusions and civil monetary penalties

CMS and Its Contractors

- Runs Medicare and oversees Medicaid
- MACs, RACs, UPICs, SMRC review claims
- RADV audits of MA payments
- Part C/D program audits and sanctions

How Findings Move Through the System

OIG Reports

Audit findings and recommendations to CMS, providers and plans

CMS Action

New edits, contractor audits, RADV, policy changes and education

Enforcement

DOJ False Claims Act cases, settlements and exclusions

How to Use the OIG Work Plan



Monitor

Check the Work Plan and new reports monthly

Map

Match items to your services and payers

Assess

Pull data and audit a sample

Act

Correct, educate and re-audit

"Nationwide Audits of Medicare Part C High-Risk Diagnosis Codes" - reviewing whether diagnosis codes submitted for risk adjustment complied with federal requirements, focusing on high-risk codes that increased risk-adjusted payments.

OIG Work Plan item SRS-A-25-021 (announced July 2023; series completion estimated FY 2028)

Monitor Findings and Active Initiatives

- Published reports show what already failed elsewhere
- Active Work Plan items show what is being reviewed now
- CMS memos and audit notices show what is coming to you
- DOJ settlements show what conduct becomes fraud



Build a Watch List

Assign an owner to review OIG reports, Work Plan updates, CMS memos and DOJ releases each month and log what applies.

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Medicare Advantage & Risk Adjustment

What OIG audits reveal and how to prepare for RADV

How Risk Adjustment Drives MA Payment

- CMS pays MA plans a risk-adjusted amount per enrollee
- Diagnoses from acceptable face-to-face encounters map to HCCs
- Higher HCCs mean higher payment, so errors cost money
- Every submitted diagnosis must be supported by the medical record



Why It Matters

An unsupported diagnosis is an overpayment. Plans must correct it, and providers who document and code it share responsibility.

What OIG Finds in MA Audits

Unsupported Codes

Diagnosis submitted but the medical record does not support it

Weak Support

No evidence the condition was assessed or treated at the visit

Rule Violations

Diagnosis not meeting coding or reporting requirements

OIG Finding: Priority Health (2026)

252/300

Sampled enrollee-years with unsupported high-risk diagnosis codes

$828K

Net overpayments in the sample ($828,010)

$4.4M

Estimated net overpayments for 2018 and 2019

Source: HHS-OIG A-07-22-01208, Priority Health (Contract H2320), issued March 31, 2026

What OIG Recommended to Priority Health

- Refund $4,479,698 in estimated net overpayments
- Find similar noncompliance after the audit period and refund it
- Strengthen compliance procedures for high-risk diagnosis codes
- Priority disagreed with the recommendations; status is open



Teaching Point

A diagnosis in the chart or on a problem list is not enough. Validate the documentation that supports each submitted code.

Supported vs. Unsupported Diagnoses

Supported

- Assessed at the encounter (status, plan)
- Acceptable provider and visit type
- Specific and consistent with the record
- Signed and dated by the provider

Red Flags

- Problem-list or history-only mention
- Acute condition coded at office follow-up
- Conflicts with labs, meds or vitals
- Added by addendum long after the visit

OIG Finding: Acute Stroke Diagnoses (2026)

$462M

Estimated potential net overpayments to MA organizations for 2021

97/97

Sampled enrollees whose acute stroke codes were unsupported

2021

Year reviewed: stroke codes on physician records with no hospital stroke record

Source: HHS-OIG A-02-23-01020, issued May 28, 2026

Why Acute Stroke Codes Fail Validation

- Acute stroke (I63.-) is coded for the initial hospital episode
- After discharge, use history (Z86.73) or sequelae (I69.-) codes
- Office notes often carry "stroke" forward from the problem list
- No hospital claim for the year is a strong data red flag



Teaching Point

Target high-risk diagnoses: validate against the record, care setting and coding guidelines, and compare to claims data.

Other High-Risk Diagnosis Groups OIG Targets

- Acute stroke and acute myocardial infarction
- Embolism and vascular claudication
- Lung, breast, colon and prostate cancer
- Major depressive disorder and potentially mis-keyed codes



Data Tests

Look for acute codes without a hospital stay, cancer without treatment, and diagnoses with no supporting medication or lab.

Enforcement: MA Risk Adjustment Settlements

$556M

Kaiser Permanente affiliates (Jan 2026), resolving addenda allegations

$117.7M

Aetna (Mar 2026): chart review and morbid obesity allegations

~500K

Diagnoses DOJ alleged Kaiser added through addenda

Sources: DOJ announcements January 14, 2026 (Kaiser) and March 10, 2026 (Aetna). Allegations only; no admission of liability.

Lessons from Kaiser and Aetna

What DOJ Alleged

- Addenda months after the visit
- Coding targets tied to incentives
- Chart reviews used only to add codes
- Obesity codes BMI did not support

Compliant Practice

- Timely, clinically driven addenda
- No pay tied to coding volume
- Two-way reviews: add and delete
- Validate codes against vitals and labs

The RADV Audit Process



Selection

CMS selects the contract and enrollee sample

Retrieval

Plan obtains medical records from providers

Review

Certified coders validate each HCC

Recovery

Payment errors calculated and recovered

CMS Expanded RADV in May 2025

~550

MA contracts audited each payment year, up from about 60

~2,000

Medical coders planned, up from 40

200

Records per contract, up from about 35

Source: CMS RADV announcement, May 21, 2025 (as summarized by Mintz); CMS planned to complete PY 2018-2024 audits by early 2026

RADV in 2026: Legal Status and Activity

- Sept 2025: federal court vacated CMS's 2023 RADV rule
- HHS appealed; Fifth Circuit heard argument Oct 5, 2026
- Jan 2026: PY 2019 audits underway; PY 2020 to follow
- CMS said new audits would start every three months



Teaching Point

Litigation does not stop audits. Treat RADV readiness as ongoing: retrieval, validation, audit trails and corrective action.

Provider and Health Plan Responsibilities

Providers

- Document assessment and plan for each condition
- Code to the highest supported specificity
- Answer queries promptly and accurately
- Produce complete records on request

Health Plans

- Validate submitted codes; delete unsupported
- Oversee vendors, chart reviews and HRAs
- Track and refund identified overpayments
- Run corrective action and re-audits

OIG's MA Compliance Guidance (Feb 2026)

Assess Risk

Annual risk assessment focused on data accuracy and payment integrity

Oversee Partners

Monitor and audit first-tier, downstream and related entities

Report Up

Share findings and corrective actions with leadership and the board

RADV Readiness Checklist



Retrieval

Track record requests, turnaround times and missing documentation.



Validation

Audit high-risk HCCs before submission and before RADV.



Audit Trail

Keep reviewer notes, deletions, refunds and corrective action records.

Audience Discussion

How does your organization validate high-risk diagnoses like acute stroke or cancer before they are submitted? Who owns deleting unsupported codes?

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Other OIG Audit Findings

Audit exposure extends well beyond Medicare Advantage

SECTION 3 | OTHER OIG AUDIT FINDINGS

E/M and Medical Necessity: Nursing Home Services

91/150

Sampled Part B items that did not meet Medicare requirements

$19.5M

Estimated improper payments by one MAC jurisdiction

4

Service types: E/M, psychotherapy, podiatry, wound care

Source: HHS-OIG A-06-21-04002, Novitas Solutions (July 2026); audit period Oct 2018 - Sept 2019

E/M Documentation Risks

- Level billed is not supported by MDM or time
- Medical necessity for frequent visits is not documented
- Cloned notes that do not reflect the patient that day
- Modifier 25 without a significant, separate service



Teaching Point

Audit E/M by provider and setting. Compare level distribution to peers and check that each note supports its own visit.

SECTION 3 | OTHER OIG AUDIT FINDINGS

Virtual Check-ins and E-visits (2026)

$1.96M

Potential improper payments for 173,287 virtual check-ins

$298K

Potential improper payments for 10,237 e-visits ($298,200)

120K

Related E/M services billed with an unnecessary modifier

Source: HHS-OIG A-05-23-00001, issued April 23, 2026

Virtual Service Billing Rules

Billable

- Patient-initiated, established patient
- Not related to an E/M in prior 7 days
- Does not lead to a visit within 24 hours
- E-visit: once per 7-day period

Red Flags

- Check-in billed with a same-issue E/M
- Multiple e-visits in 7 days, same issue
- Modifiers added to bypass edits
- No patient-initiated request on file

SECTION 3 | OTHER OIG AUDIT FINDINGS

Remote Patient Monitoring: OIG Data Brief

$500M+

Medicare and MA payments for RPM in 2024, up 31%

~1M

Patients receiving RPM services in 2024

4,600

Practices routinely billing RPM

Source: HHS-OIG OEI-02-23-00261, issued August 25, 2025

SECTION 3 | OTHER OIG AUDIT FINDINGS

Hospital Payment Compliance (2026)

27/100

Sampled inpatient and outpatient claims not fully compliant

$257K

Net overpayments in the sample ($256,926)

$12.4M

Estimated net overpayment for 2020-2021

Source: HHS-OIG A-09-23-03001, Methodist Hospital (September 2026)

SECTION 3 | OTHER OIG AUDIT FINDINGS

Hospice Eligibility and Billing (2026)

15/100

Sampled hospice claims that did not meet requirements

$8.6M

Estimated overpayments for July 2020 - June 2022

6 mo.

Terminal prognosis that documentation must support

Source: HHS-OIG A-09-23-03004, Hospice of the Valley - West, issued July 28, 2026

Duplicate Billing and Claims Control Weaknesses

- Same service billed twice or by two providers
- Services billed inside timeframes that bundle them
- Modifiers used to override edits without support
- Payer edits missing, so errors are paid, not caught



Teaching Point

Do not rely on payer edits. Build front-end claim scrubber rules for frequency limits, timeframes and modifier use.

Other Areas to Watch for Your Audience

- Behavioral health: psychotherapy time and documentation
- Telehealth and telemedicine-linked DME and genetic testing
- Wound care and skin substitutes
- Medicaid managed care: encounter data and payment accuracy



Choose What Applies

Pick the two or three areas that match your services and payers, then audit a sample this quarter.

Common Control Failures in These Audits



Unfollowed Policies

Hospital and hospice audits: written procedures existed but were not applied



Missing Edits

Virtual check-ins and acute stroke: no filter to stop the claim or code



Education Gaps

Nursing home and virtual services: providers unclear on requirements

Audience Discussion

Which of these findings would your organization fail today if OIG pulled a sample of 100 claims? What would you check first?

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CMS Audits & Enforcement

Program audits, new oversight tools and the overpayment rule

SECTION 4 | CMS AUDITS & ENFORCEMENT

CMS Part C and Part D Program Audits (2025)

$1.54M

Civil money penalties CMS imposed

14

Enforcement actions

#1

Finding area: beneficiary cost sharing and provider payments

Source: CMS CY 2025 Part C and Part D Program Audit and Enforcement Report (released July 2026)

WISeR: Prior Authorization in Traditional Medicare

- Runs January 1, 2026 through December 31, 2031
- Six states: AZ, NJ, OH, OK, TX, WA
- Selected services such as skin substitutes and nerve stimulation
- AI-assisted review; a clinician must review every denial

Why It Matters

Technology-driven review is spreading. Documentation must support medical necessity before the service, not after.

The 60-Day Overpayment Rule

- Report and return within 60 days of identification
- Up to 180 days of good-faith investigation can pause the clock
- Applies to Medicare and Medicaid; MA plans have parallel duties
- Retained overpayments can create False Claims Act liability



Teaching Point

Document when a potential overpayment was found, the investigation, the quantification and the refund.

Audit Notice Received: Do and Don't

Do

- Log deadlines and the reviewer
- Pull complete, signed records
- Have compliance review first
- Track results and appeal rights

Don't

- Send partial or late records
- Add late entries to the chart
- Ignore the look-back scope
- Assume one bad claim is isolated

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Turning Audit Findings into an Action Plan

Identify, audit, validate and track

A Four-Step Compliance Cycle



Identify

High-risk services, diagnoses and providers

Audit

Targeted prepayment and retrospective reviews

Validate

Documentation, coding and claim data

Track

Refunds, corrective action and re-audit

Step 1: Identify High-Risk Areas

- Map OIG findings and Work Plan items to your services
- Run data tests: acute codes without hospital stays
- Flag outliers by provider, code and frequency
- Rank by dollars, volume and likelihood of error



Start Here

High-risk HCCs, E/M levels, virtual services and any service tied to a recent OIG report.

Prepayment vs. Retrospective Audits

Prepayment

- Stops errors before claims go out
- Best for new services and providers
- Feeds real-time education
- Can slow cash flow; keep it targeted

Retrospective

- Measures error rates over time
- Identifies overpayments to refund
- Supports look-back sizing
- Starts the 60-day clock when found

Step 3: Validate Documentation, Coding and Claims



Documentation

Each diagnosis and service is supported in the note for that date



Coding

Codes, modifiers and units follow guidelines and payer rules



Claim Data

What was submitted matches the record and the remittance

Step 4: Track and Close the Loop



Overpayments

Log each finding, its quantification, refund date and payer.



Corrective Action

Assign an owner, due date and the policy, edit or training fix.



Re-audit

Re-test in 60-90 days and report results to leadership.

Audience Discussion

Case scenario: A data test finds 40 acute stroke codes from office visits with no hospital stay that year. What do you do in the next 60 days?

NEXT STEPS

Your 30-Day Compliance Action Plan

Wk 1

Watch List

Assign an owner; review OIG, CMS and DOJ updates

Wk 2

Data Tests

Run high-risk HCC, E/M and virtual service tests

Wk 3

Targeted Audit

Audit a sample; quantify errors and overpayments

Wk 4

Correct

Refund, educate, add edits and set a re-audit date

WRAP UP

Key Takeaways



Findings Become Audits

OIG reports turn into CMS edits, audits and DOJ cases; act before they reach you.



Support Every Code

A diagnosis in the chart is not support; validate high-risk codes before submission.



Controls, Not Policies

Follow your policies, build edits, train staff and re-audit.

RESOURCES

References

- OIG A-07-22-01208 (Priority Health); A-02-23-01020 (acute stroke)
- OIG A-05-23-00001 (virtual check-ins); OEI-02-23-00261 (RPM)
- OIG A-06-21-04002 (Novitas); A-09-23-03001; A-09-23-03004
- OIG MA Compliance Program Guidance (Feb 2026); Work Plan

Official Sources

oig.hhs.gov/reports | oig.hhs.gov/reports/work-plan | cms.gov Part C and D Program Audits | justice.gov

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Questions and discussion