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Potential Vulnerabilities in CMS's Oversight of Medicare Providers' Billing of Selected Outpatient Drugs

REPORT HIGHLIGHTS



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Why OIG Did This Data Brief

- Medicare Part B provides coverage for certain outpatient drugs. Providers use procedure codes on Medicare outpatient claims to identify drugs administered to enrollees. Providers use [CMS](#) crosswalk files to select and bill the procedure code associated with the drug code. CMS contracts with Medicare Administrative Contractors (MACs) to, among other things, process and pay Part B claims.
- Our analysis of CMS claims data with dates of service from April 1, 2024, through March 31, 2025, found that providers billed 160,918 Part B claim lines for outpatient drugs with 577 unique procedure codes that did not match the procedure codes associated with the drug codes included on the claim lines.
- We analyzed these claim lines to highlight providers' billing trends and patterns and to identify any vulnerabilities in CMS's oversight of these billings.

What OIG Found

Our analysis of 160,918 claim lines for outpatient drugs billed with procedure codes that did not match the procedure codes associated with the drug codes in the crosswalk files showed:

- Six procedure codes were associated with 62 percent of these outpatient drugs.
- Two provider types (critical access hospitals and short-term acute-care hospitals) billed for 99 percent of these outpatient drugs.
- One short-term acute-care hospital billed for 7 percent of these outpatient drugs.

We identified two potential vulnerabilities related to CMS's and MACs' oversight of providers' billing of drugs:

- They did not have system edits to ensure providers used the correct procedure code when billing for outpatient drugs.
- Their provider education activities did not address billing for drugs using procedure codes that match those associated with the drug codes in CMS crosswalk files.

Our review of 30 nonstatistically sampled claim lines found that providers billed for outpatient drugs using incorrect procedure codes for 24 claim lines. Of the remaining six claim lines, providers billed for the correct Healthcare Common Procedure Coding System (HCPCS) codes and National Drug Codes (NDCs) on three claims lines and billed for the correct HCPCS codes but included the incorrect NDCs on the other three claim lines.

This data brief does not contain any specific recommendations to CMS. However, information in this data brief may help CMS and the MACs strengthen future oversight to ensure that providers correctly bill for outpatient drugs and protect taxpayer dollars.



U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

HHS OIG Data Brief • OAS-25-09-090

Potential Vulnerabilities in CMS's Oversight of Medicare Providers' Billing of Selected Outpatient Drugs

Key Takeaways:

Providers billed Medicare for 160,918 claim lines for outpatient drugs that may have been billed with an incorrect procedure code or drug code. Our data analysis covered April 2024 through March 2025 and indicated that:

- Six procedure codes were associated with 62 percent of these drugs.
- Critical access hospitals and short-term acute-care hospitals billed for 99 percent of these drugs.
- One short-term acute-care hospital billed for 7 percent of these drugs.

Although providers are not always required to include a drug code on a claim line, the Centers for Medicare & Medicaid Services (CMS) officials acknowledged that billing an incorrect procedure code could significantly impact providers' payments if the providers are paid under the Medicare Hospital Outpatient Prospective Payment System (OPPS).

We identified potential vulnerabilities related to CMS's and the Medicare Administrative Contractors' (MACs') oversight of providers' billing of these drugs. Specifically: (1) they did not have system edits to ensure providers used correct procedure codes when billing for drugs and (2) their provider education did not address billing for drugs using correct procedure codes.

Purpose of This Data Brief

Providers use procedure codes on Medicare outpatient claims to identify drugs administered to enrollees. Providers can also include the drug code on Medicare claims, but they are only required to include the drug code if the enrollee is dually eligible for Medicare and Medicaid. To ensure accurate reimbursement, providers use CMS's crosswalk files to select and bill the procedure code associated with the drug code.

The objective of this audit was to analyze data related to providers' billing of drugs with procedure codes that did not match the procedure codes associated with the drug codes included on the claim lines and determine whether there are any vulnerabilities in CMS's oversight of these billings.

Information in this data brief may help CMS and MACs strengthen future oversight to ensure that providers correctly bill for outpatient drugs and protect taxpayer dollars.

BACKGROUND

Medicare Program

Medicare provides health insurance for people aged 65 and older, people with disabilities, and people with permanent kidney disease. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage for certain drugs administered to enrollees. CMS administers the Medicare program and contracts with MACs to, among other things, process and pay Part B claims for a defined geographic area (jurisdiction). For claim lines with dates of service from April 1, 2024, through March 31, 2025 (audit period), seven MACs processed and paid Medicare Part B claims.

MACs help CMS promote Medicare compliance within their jurisdictions. CMS and MACs provide education and guidance to providers on Medicare requirements and billing procedures. MACs also review medical records for selected claims within their jurisdictions.

Providers' Billing for Outpatient Drugs

Medicare requires providers to submit accurate claims for outpatient services. Each claim may contain multiple claim lines that detail the services provided, including the drugs administered. Providers use Healthcare Common Procedure Coding System (HCPCS) codes on claim lines to identify drugs administered to enrollees.¹

Generally, certain providers, such as short-term acute-care hospitals' outpatient departments, bill for services, including drugs, under the OPPS.² Under this system, drugs are either bundled into the primary service's Ambulatory Payment Classification (APC) rate or paid separately.^{3, 4}

Other types of providers, such as critical access hospitals, bill for outpatient services, including drugs, under different payment systems and are not paid based on an APC rate. For example, critical access hospitals receive 101 percent of their reasonable costs for outpatient services provided (i.e., reasonable cost basis).⁵

¹ The Social Security Act § 1833(e), 42 CFR §§ 424.5(a)(6) and 424.32(a)(1), and CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 17, section 90.2.A, provide overall requirements related to the billing of outpatient services.

² Some short-term acute-care hospitals (e.g., those located in Maryland) are not paid under the OPPS.

³ The APC uses HCPCS codes and bundles similar services and procedures to determine standardized payment rates.

⁴ Drugs with specific payment status indicators (e.g., K for non-pass-through drugs and biologicals) receive separate payment.

⁵ Reasonable costs are the direct and indirect costs associated with provided services to Medicare enrollees (42 CFR §§ 413.9(b)(1) and (c)(3)).

National Drug Codes

A National Drug Code (NDC) is a unique 11-character number assigned by the Food and Drug Administration to identify drugs, including their strength, manufacturer, and package size, in the United States. Many NDCs are assigned a HCPCS code pairing, which is included in NDC/HCPCS crosswalk files for Medicare Part B drugs that are maintained by CMS. NDCs are used to identify which HCPCS code providers should bill, but Medicare does not require providers to include NDCs on claim lines unless the associated enrollee is dually eligible for Medicare and Medicaid or under specific program requirements.⁶ Although providers are not always required to include an NDC on a claim line, CMS officials stated that billing an incorrect HCPCS code could significantly impact providers' payment if the providers are paid under the OPPOS. However, there is no impact on payment if the providers, such as critical access hospitals, are paid under different payment systems.

Data Used To Develop This Data Brief

Our primary source of data was CMS's National Claims History (NCH) file. Providers billed for outpatient drugs on 10.5 million claim lines with dates of service during our audit period that included both a HCPCS code and an NDC. Medicare paid \$17.3 billion for these claim lines. We used the NDC/HCPCS crosswalk files to identify instances for which providers billed for drugs on Medicare Part B outpatient claims using both HCPCS codes and NDCs, but the HCPCS codes were not associated with the NDCs in the NDC/HCPCS crosswalk files.⁷

We analyzed the 10.5 million claim lines and identified 160,918 claim lines for outpatient drugs billed by 2,944 providers for 577 unique HCPCS codes that did not match the HCPCS codes associated with the NDCs in the NDC/HCPCS crosswalk files. Medicare paid \$27.6 million for these claim lines.⁸ Of these 160,918 claim lines, providers received payments of \$21.7 million for 33,617 claim lines under the OPPOS and \$5.9 million for 127,301 claim lines under different payment systems (e.g., reasonable cost basis). We further analyzed the 160,918 claim lines to highlight providers' billing trends and patterns.

We also used the data to select a nonstatistical sample of 30 claim lines for review. Specifically, we selected 1 claim line from each of the 30 most frequently billed HCPCS codes for which the

⁶ The Deficit Reduction Act of 2005 required State Medicaid agencies to provide for the collection of NDCs billed by providers on all claims for certain drugs for the purpose of billing manufacturers for Medicaid drug rebates.

⁷ We used both CMS's Medicare Part B drug NDC/HCPCS crosswalk files and the Pricing, Data Analysis, and Coding (PDAC) contractor's NDC/HCPCS crosswalk files. Although the PDAC crosswalk applies to claims submitted to the Durable Medical Equipment MACs, we included it in our analysis to broaden the set of available NDC-to-HCPCS matches. The PDAC crosswalk contains some of the same NDC-to-HCPCS matches found in CMS's Medicare Part B crosswalk.

⁸ We did not determine whether any overpayments or underpayments occurred for these claim lines because our audit focused on analyzing data related to providers' billing of drugs with HCPCS codes that did not match the HCPCS codes associated with the NDCs included on the claim lines.

code description did not have a similar drug name to another selected claim line.^{9, 10} For each claim line, we requested and reviewed supporting documentation from providers to determine whether they billed for the drugs using the correct HCPCS codes and NDCs. We confirmed our determinations with the providers.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

The appendix describes our audit scope and methodology.

RESULTS OF ANALYSIS

Our analysis of 160,918 claim lines for outpatient drugs billed with dates of service during our audit period with HCPCS codes that did not match HCPCS codes associated with the NDCs in the NDC/HCPCS crosswalk files found:

- Providers consistently billed for 38,512 to 42,994 claim lines with HCPCS codes that did not match those associated with the NDCs in the NDC/HCPCS crosswalk files for each quarter.
- Six HCPCS codes were associated with 62 percent of these outpatient drugs.
- Two provider types—critical access hospitals and short-term acute-care hospitals—billed for 99 percent of these outpatient drugs.
- One short-term acute-care hospital billed for 7 percent of these outpatient drugs.

Furthermore, for 24 of the 30 nonstatistically sampled claim lines, providers billed claim lines using incorrect HCPCS codes, which could have resulted in improper payments for 11 claim lines.¹¹ The providers attributed these incorrect billings to clerical errors and billing system issues. Of the remaining six claim lines, providers billed for the correct HCPCS codes and NDCs

⁹ These 30 claim lines were billed by 30 providers—15 that were under the OPPS and 15 that were under different payment systems.

¹⁰ For example, we only selected one claim line for the most frequently billed version of saline solution; we did not select any claim lines for other versions of the drug.

¹¹ Of the 24 sampled claim lines, 11 were reimbursed under the OPPS, which could have resulted in improper payments. The remaining 13 sampled claim lines were reimbursed under different payment systems, which would not have resulted in improper payments.

on three claims lines and billed for the correct HCPCS codes but included the incorrect NDCs on the other three claim lines.¹²

We identified two potential vulnerabilities related to CMS's and the MACs' oversight of providers' billing of drugs: (1) they did not have system edits to ensure that providers used the correct HCPCS code when billing for outpatient drugs and (2) their provider education activities did not address billing for drugs using HCPCS codes that match those associated with the drugs' NDC(s).

Providers' Billing Trends and Patterns for Selected Outpatient Drugs Billed With HCPCS Codes That Did Not Match HCPCS Codes Associated With the NDCs

Our analysis of 160,918 claim lines for outpatient drugs billed with HCPCS codes that did not match HCPCS codes associated with the NDCs in the NDC/HCPCS crosswalk files found certain billing trends and patterns that may be of interest to stakeholders, including CMS and the MACs. Medicare paid \$27.6 million for these claim lines.

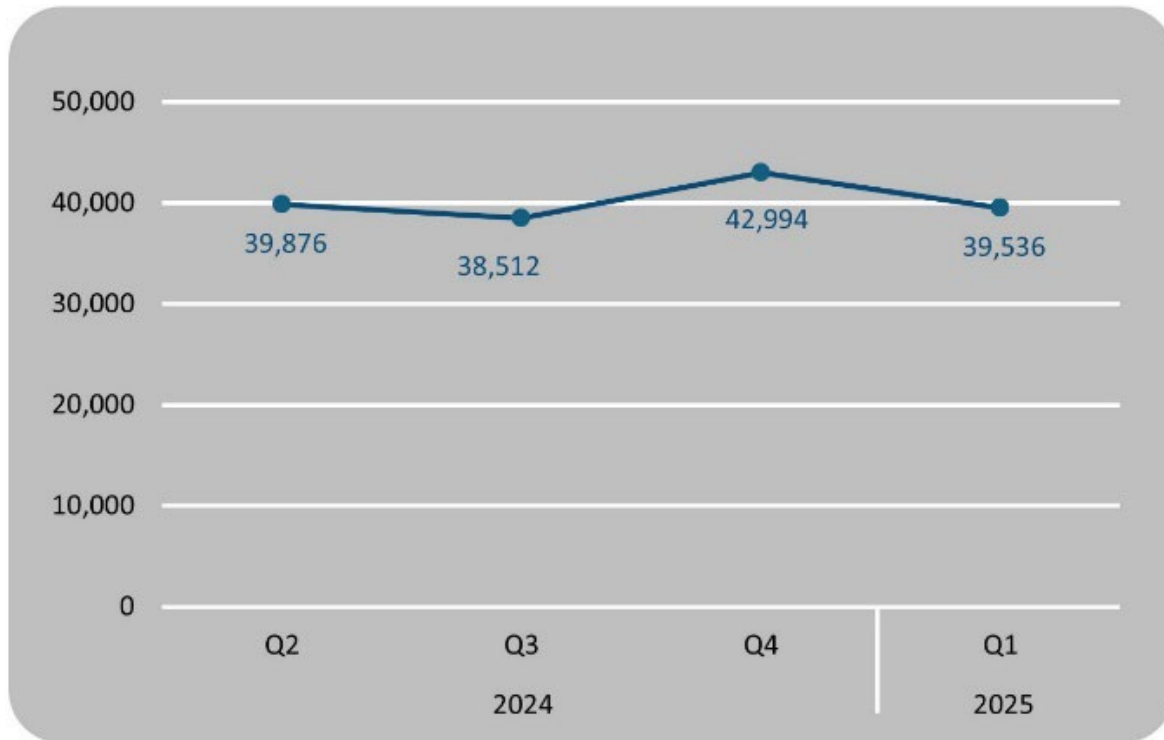
Medicare Paid Providers Between 38,000 and 43,000 Claim Lines Quarterly for Selected Outpatient Drugs

Medicare paid for 160,918 claim lines billed with HCPCS codes that did not match those associated with the NDCs in the NDC/HCPCS crosswalk files.¹³ These claim lines show that providers consistently billed 38,512 to 42,994 claim lines with HCPCS codes that did not match those associated with the NDCs in the NDC/HCPCS crosswalk files for each quarter. See Figure 1 on the next page.

¹² These six providers were properly paid because they billed for the correct HCPCS codes.

¹³ See footnote 10.

Figure 1: Number of Claim Lines Providers Billed for Outpatient Drugs in Which the HCPCS Codes Billed Did Not Match Those Associated With the NDCs

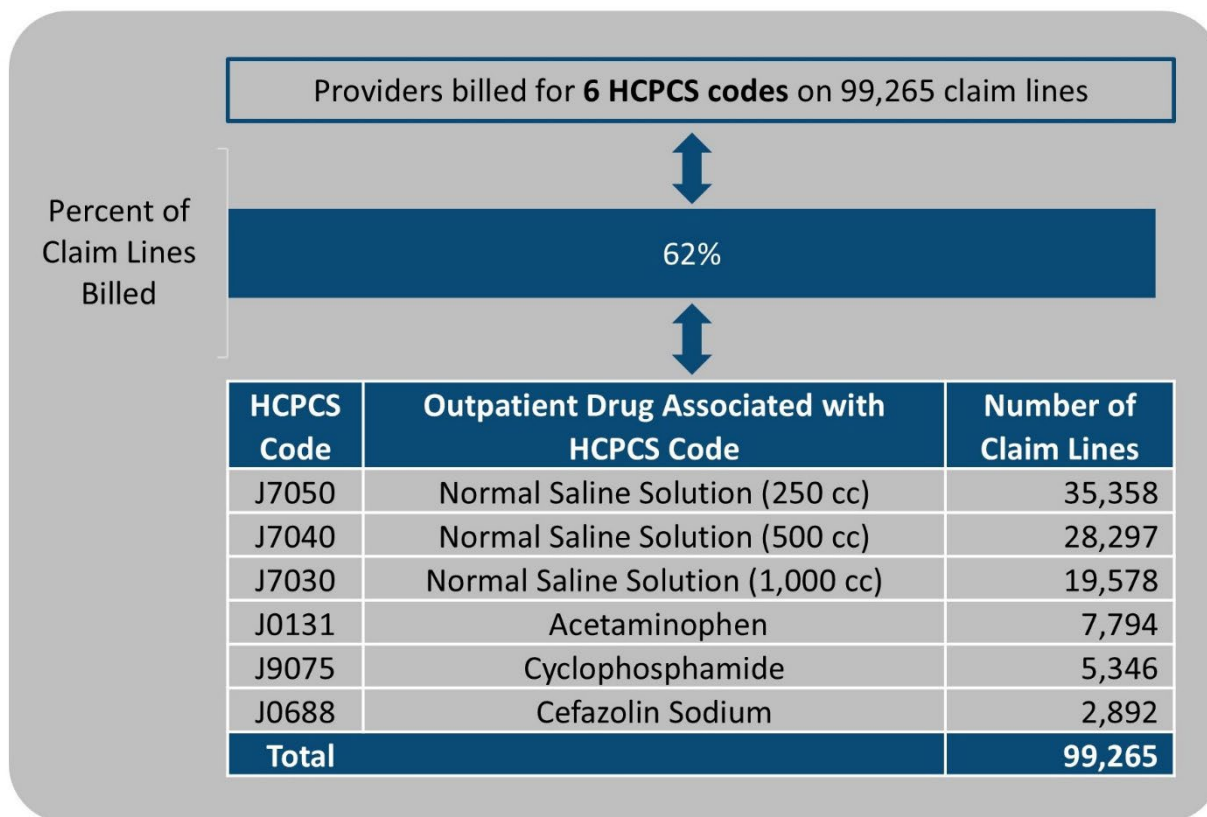


Providers Billed for Six HCPCS Codes That Accounted for 62 Percent of the Selected Outpatient Drugs

For claim lines with dates of service during our audit period, 6 HCPCS codes accounted for 62 percent (99,265 claim lines) of the 160,918 claim lines that did not match those associated with the NDCs in the NDC/HCPCS crosswalk files.¹⁴ See Figure 2 on the next page.

¹⁴ The remaining 38 percent (61,653 claim lines) included 571 HCPCS codes that did not match those associated with the NDCs in the NDC/HCPCS crosswalk files.

Figure 2: Six HCPCS Codes Accounted for 62 Percent of Outpatient Drugs Billed by Individual Providers for Which the HCPCS Codes Billed Did Not Match Those Associated With the NDCs

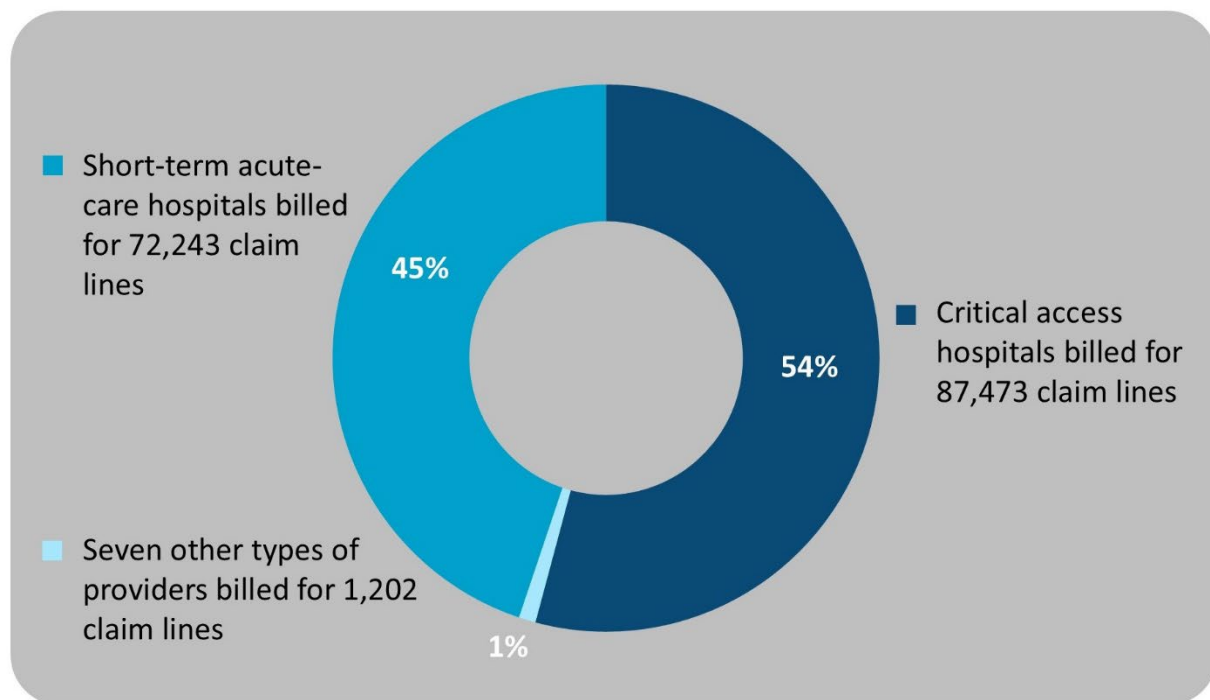


Two Provider Types Billed for 99 Percent of the Selected Outpatient Drugs in Which the HCPCS Codes Billed Did Not Match Those Associated With the NDCs

For claim lines with dates of service during our audit period, two provider types—critical access hospitals and short-term acute-care hospitals—billed for 99 percent of the 160,918 claim lines for which the HCPCS codes billed did not match those associated with the NDCs in the NDC/HCPCS crosswalk files. Specifically, critical access hospitals billed for 87,473 claim lines (54 percent), and short-term acute-care hospitals billed for 72,243 claim lines (45 percent). Seven other types of providers billed for the remaining 1,202 claim lines (1 percent). See Figure 3 on the next page.¹⁵

¹⁵ The other types of providers included renal dialysis facilities, skilled nursing facilities, children's hospitals, long-term hospitals, psychiatric hospitals, rehabilitation hospitals, and home health agencies.

Figure 3: Types of Providers That Billed for Outpatient Drugs in Which the HCPCS Codes Billed Did Not Match Those Associated With the NDCs



One Provider Billed for 7 Percent of the Selected Outpatient Drugs in Which the HCPCS Codes Billed Did Not Match Those Associated With the NDCs

For claim lines with dates of service during our audit period, 1 short-term acute care hospital billed for 7 percent (11,374 claim lines) of the 160,918 claim lines for which the HCPCS codes billed did not match those associated with the NDCs in the NDC/HCPCS crosswalk files.¹⁶ Each of the remaining 2,943 providers billed for less than 2 percent of the claim lines (3,300 claim lines), totaling 149,544 claim lines.

Providers' Incorrect Billing for Sampled Outpatient Drugs

Of the 30 nonstatistically sampled claim lines we reviewed, providers correctly billed for outpatient drugs (i.e., billed using correct HCPCS codes and NDCs) on 3 claim lines and billed the correct HCPCS codes but included the incorrect NDCs on 3 other claim lines. However, for the remaining 24 nonstatistically sampled claim lines, providers billed for outpatient drugs using incorrect HCPCS codes.¹⁷

¹⁶ This hospital was under a payment system (i.e., Maryland All-Payer Model) for which billing the incorrect HCPCS code on claim lines would not have resulted in an improper payment.

¹⁷ We discussed the errors with the providers that billed for the 24 claim lines and requested them to adjust their claims with the correct HCPCS codes. As of the issuance of this data brief, 7 of the 24 claim lines had been adjusted.

Federal Requirements

Providers are required to submit accurate and complete bills to Medicare for allowable and covered services, including using the correct HCPCS code for each drug administered to a Medicare enrollee.¹⁸

Providers Billed for Outpatient Drugs Using the Incorrect HCPCS Codes

For 24 sampled claim lines, providers billed for outpatient drugs using the incorrect HCPCS code. Of the 24 sampled claim lines, 11 were reimbursed under the OPPS, which could have resulted in calculated net improper payments of \$1,304.¹⁹ Because the remaining 13 sampled claim lines were reimbursed under different payment systems, the providers did not receive improper payments for billing the wrong HCPCS code.

Providers attributed the billing of outpatient drugs with incorrect HCPCS codes to clerical errors and to provider billing systems that could not prevent or detect the incorrect billing of outpatient drugs. For example, one provider stated that it was not aware of a change in the NDC associated with a HCPCS code; therefore, it did not update its billing system with the correct HCPCS code.

Example of a Provider Incorrectly Billing for a Drug Different From What Was Administered

A provider administered a 120-milligram injection of lanreotide, a drug used to treat a condition caused by excessive secretion of a growth hormone. The provider billed for the administration of the drug using HCPCS code J1930. However, the medical record indicated that the provider administered a version of the drug that maps to HCPCS code J1932. As a result of the provider's using the wrong HCPCS code, the MAC paid the provider \$4,701 when it should have paid \$3,462—an overpayment of \$1,239.

In addition, some providers stated that they billed for outpatient drugs with incorrect HCPCS codes because they used the drug labeler's names, which were included in the HCPCS code descriptions, instead of billing for the drugs with the HCPCS codes associated with the NDCs included in the NDC/HCPCS crosswalk files.²⁰

Potential Vulnerabilities Related to CMS and Medicare Administrative Contractors' Oversight of Providers' Billing of Outpatient Drugs

CMS and the MACs conducted oversight activities to prevent or detect providers' billing for incorrect HCPCS codes. However, these activities were not sufficient to prevent or detect providers' billing for HCPCS codes that did not match those associated with the NDCs in the NDC/HCPCS crosswalk files.

¹⁸ The Social Security Act § 1833(e), 42 CFR §§ 424.5(a)(6) and 424.32(a)(1), and CMS's Medicare Claims Processing Manual, Pub. No. 100-04, chapter 17, section 90.2.A.

¹⁹ This net improper payment amount includes both overpayments and underpayments.

²⁰ A drug labeler is a company that manufactures, including repackaging or relabeling, or distributes a drug under its own name.

We identified two potential vulnerabilities related to CMS's and the MACs' oversight of providers' billing of outpatient drugs: (1) they did not have system edits to ensure that providers were billing for drugs with the correct HCPCS code and (2) their provider education activities did not address billing for drugs using HCPCS codes that matched the HCPCS codes associated with the drugs' NDCs.

CMS's and Medicare Administrative Contractors' System Edits Were Insufficient

For claim lines with dates of service during our audit period, CMS and some MACs had system edits for some HCPCS codes to ensure that claim lines billed with these codes were billed with a valid NDC. However, there were no system edits to ensure that providers billed for HCPCS codes that matched those associated with the NDCs in the NDC/HCPCS crosswalk files. In addition, since providers are not always required to include the NDCs when billing for HCPCS codes, claim lines billed with HCPCS codes without NDCs may be able to bypass system edits.

CMS's and Medicare Administrative Contractors' Provider Education Was Insufficient

For claim lines with dates of service during our audit period, CMS's and the MACs' provider education activities did not include sufficient detail about billing for HCPCS codes that matched those associated with the NDCs in the NDC/HCPCS crosswalk files. CMS posted articles on its website related to billing for drugs, including how to report on unused and discarded amounts from single-dose containers, and how certain providers can report drugs that are excluded from Part B inflation rebates. In addition, most MACs referred providers to articles or frequently asked questions posted on their websites; some MACs hosted webinars on topics related to billing for drugs, including how to report NDCs on a claim line. However, these education materials did not go into detail about ensuring that providers bill for HCPCS codes that matched those associated with the NDCs in the NDC/HCPCS crosswalk files.

CONCLUSION

Providers billed Medicare for 160,918 claim lines for outpatient drugs with dates of service during our audit period that may have been billed with incorrect HCPCS codes or NDCs. In addition, of the nonstatistically selected 30 sampled claim lines for outpatient drugs, 24 were incorrectly billed with the incorrect HCPCS codes, which could have resulted in improper payments for the providers paid under the OPPS. Although providers are not always required to include an NDC on a claim line, CMS officials acknowledged that billing an incorrect HCPCS code could significantly impact providers' payments if the providers are paid under the OPPS. Medicare also requires providers to submit accurate claims for outpatient services.

We also identified potential vulnerabilities related to CMS's and the MACs' oversight of providers' billing of these outpatient drugs. Specifically: (1) there were no system edits to ensure that providers bill for drugs with the correct HCPCS code and (2) provider education did not address billing for drugs using HCPCS codes that match those associated with the drugs' NDCs in the NDC/HCPCS crosswalk files.

Information in this data brief may help CMS and the MACs strengthen future oversight to ensure that providers correctly bill for outpatient drugs and protect taxpayer dollars.

We issued a draft of this data brief to CMS. CMS furnished technical comments, which we addressed as appropriate.

APPENDIX: AUDIT SCOPE AND METHODOLOGY

Scope

Our primary source of data for this data brief was CMS's NCH file, in which providers billed for outpatient drugs on 10,527,895 claim lines that included both a HCPCS code and an NDC. Medicare paid \$17,275,445,011 for these claim lines. We also used the NDC/HCPCS crosswalk files to identify instances in which HCPCS codes billed for drugs on Medicare Part B outpatient claims did not match HCPCS codes associated with the NDCs in the NDC/HCPCS crosswalk files with dates of service from April 1, 2024, through March 31, 2025. We analyzed the 10,527,895 claim lines and identified 160,918 claim lines billed by 2,944 providers for 577 unique billed HCPCS codes that did not match the HCPCS codes associated with the NDCs in the NDC/HCPCS crosswalk files. Medicare paid \$27,589,634 for these claim lines. Of these 160,918 claim lines, providers received payments of \$21,713,181 for 33,617 claim lines under the OPPS and \$5,876,453 for 127,301 claim lines under different payment systems.

We further analyzed the 160,918 claim lines to highlight providers' billing trends and patterns. We also used the claim data to select a nonstatistical sample of 30 claim lines for review, for which we requested and reviewed supporting documentation from the providers to determine whether they billed for the drugs using the correct HCPCS codes and NDCs. We confirmed our determinations with the providers.

We did not perform an overall assessment of the internal control structure of CMS and the MACs. Rather, we limited our review to those controls that were significant to our audit objective. Specifically, we interviewed CMS and MAC officials about the oversight activities (i.e., system edits and provider education activities) related to providers' billing of outpatient drugs using HCPCS codes and NDCs and reviewed CMS and the MACs' requirements and guidance related to billing of these drugs. Because our audit was designed to provide only reasonable assurance that the internal controls we reviewed were effective, it would not necessarily have detected all internal control deficiencies.

Our audit enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file, but we did not assess the completeness of the data. We assessed the reliability of the data obtained from the NCH file by: (1) considering prior data reliability assessments on data from the NCH file, such as tracing claims to supporting documentation, and (2) performing electronic testing of the data, such as testing for missing data. We determined the data were sufficiently reliable.

We conducted our audit from June 2025 through August 2026.

Methodology

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance related to coverage of and billing for outpatient drugs
- Interviewed CMS officials to obtain an understanding of CMS's oversight of providers' billing of outpatient drugs using HCPCS codes and NDCs
- Sent questionnaires to the seven MACs related to their oversight activities of providers' billing for outpatient drugs using HCPCS codes and NDCs, and reviewed their responses
- Obtained Medicare Part B paid claim data from CMS's NCH file
- Obtained NDC/HCPCS crosswalk files from CMS's and the Pricing, Data Analysis, and Coding contractor's websites²¹
- Analyzed claim data for outpatient drugs in which the HCPCS codes billed did not match those associated with the NDCs included in the NDC/HCPCS crosswalk files to identify: (1) the number of claim lines Medicare paid providers quarterly, (2) the most frequently billed HCPCS codes, (3) the types of providers (e.g., critical access hospitals, short-term acute-care hospitals) that billed for the largest number of claim lines, and (4) the number of claim lines billed by each provider
- Selected a nonstatistical sample of 30 claim lines, for which we requested and reviewed supporting documentation to determine whether the providers billed with the correct HCPCS codes and NDCs, and confirmed our determinations with the providers²²
- Discussed the results of the audit with CMS officials

We issued a draft of this data brief to CMS. CMS furnished technical comments, which we addressed as appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions

²¹ CMS's NDC/HCPCS crosswalk files were accessed at <https://www.cms.gov/medicare/payment/part-b-drugs/asp-pricing-files>. The PDAC contractor's crosswalk files were accessed at <https://www.dmeprdac.com/palmetto/PDACv2.nsf/T/NDC+-HCPCS%20Crosswalk>.

²² Specifically, we selected 30 claim lines: 15 billed by providers under OPDS and 15 billed by providers under different payment systems. We selected 1 claim line from each of the 30 most frequently billed HCPCS codes in which the HCPCS code description did not have a similar drug name to another selected claim line in our sample. For example, we only selected one claim line for the most frequently billed version of saline solution, and we did not select any claim lines for other versions of the drug.

based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov