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2025 OIG Year in Review: Part II—Providers

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Federal health care enforcement activity in 2025 underscored long-standing compliance risk areas across the provider landscape. As detailed in *Part I: Life Sciences*, the government continued to use the False Claims Act (FCA) and other program integrity tools to address improper federal health care

spending and patient safety concerns. For health care providers, enforcement was driven less by novel legal theories and more by operational failures and weaknesses in internal monitoring and reporting systems.

This second installment of the 2025 OIG Year in Review focuses on provider-side enforcement and oversight developments, drawing from FCA resolutions, Corporate Integrity Agreements (CIAs), Health and Human Services (HHS) Office of Inspector General (OIG or HHS-OIG) evaluations and audits, and targeted enforcement actions involving hospitals, nursing homes, laboratories, pharmacies, and physician practices. As is typical in enforcement matters, most providers in the cases summarized in this article denied the allegations against them.

Across these sectors, the government repeatedly emphasized documentation integrity, medical necessity, quality-of-care accountability, and the effective use of data and compliance analytics. The developments summarized below highlight not only where enforcement occurred in 2025, but also where providers should anticipate sustained regulatory scrutiny and compliance risk in the year ahead.

Hospitals

Enforcement activity involving hospitals reflected a continued Department of Justice (DOJ) and HHS-OIG focus on core integrity risks: medically unnecessary services, improper billing, Emergency Medical Treatment and Labor Act (EMTALA) violations, and misuse of pandemic-era relief funds. DOJ continued to use the FCA as a primary enforcement tool to investigate allegations of fraud related to federal health care programs (FHCPs). Several large FCA resolutions—many accompanied by CIAs—underscore that hospitals remain a central enforcement priority.

FCA Enforcement

Community Health System (CHS), which operates in Fresno as Community Regional Medical Center and Clovis Community Medical Center, agreed to pay $31.5 million to resolve Anti-Kickback Statute (AKS) and FCA allegations that it knowingly induced physicians to submit medically unnecessary claims to FHCPs for inpatient services. The government alleged CHS pressured doctors to admit patients, paid bonuses as de facto reward referrals, and provided financial subsidies for technology used in the physicians' private office.[1] The settlement was accompanied by a five-year CIA with robust OIG oversight, including risk assessment internal review and annual independent review of certain referral-source arrangements.

DOJ consistently resolved hospital FCA matters involving alleged kickbacks paid to referral sources. New York-Presbyterian Hudson Valley Hospital agreed to pay $6.8 million to resolve kickback allegations that it entered into medical director agreements with a Westchester oncology practice and paid for services not performed.[2] A Texas hospital and a medical imaging services company agreed to pay $3.1 million to resolve allegations that the hospital improperly allowed the imaging company to use the hospital's provider identification to bill FHCPs in exchange for 17% of the amount billed.[3] These two resolutions suggest ongoing enforcement risk where hospitals' financial relationships with physician groups or service vendors are not appropriately structured, documented, and monitored for AKS compliance.

Several additional hospital FCA resolutions in 2025 addressed allegations involving medically unnecessary services, clinical research billing, documentation deficiencies, or cost reporting errors, reinforcing DOJ's continued focus on core hospital billing and utilization controls.

OIG Audits and Evaluations

HHS-OIG issues audits and evaluations that identify compliance risk areas for health care providers. OIG's workplan is a valuable resource, highlighting high-risk areas that providers should use to inform risk-based compliance auditing and monitoring efforts. Below is a brief summary of important OIG audits and evaluations related to hospital compliance with federal requirements.

Patient Harm Events

In a widely cited OIG Office of Evaluation and Inspection (OEI) report,[4] OIG found that hospitals failed to capture approximately 50% of patient harm events that occurred during inpatient stays. OEI concluded that hospital incident reporting systems significantly undercounted adverse events and applied narrow definitions of harm, limiting the ability of hospitals and regulators to identify systemic safety risks. Another OEI report emphasized that many serious events were documented in medical records but were never reported through hospital safety reporting systems.[5] OIG warned that underreporting undermines quality improvement efforts and masks patterns of substandard care that could later draw regulatory or enforcement scrutiny.

Provider Relief Funds

OIG's 2025 audits of hospital compliance with Provider Relief Fund (PRF) requirements revealed persistent risk areas long after the public health emergency. OIG's audit found that 11 of 30 sampled hospitals did not comply with federal requirements for expending PRF payments. OIG noted weak interpretation of guidance, inadequate supporting documentation, and deficient internal controls.[6] In a related audit, 17 of 25 hospitals billed COVID-19 inpatients amounts that did not comply with the PRF's balance-billing requirement, in some cases collecting more than patients' in-network cost-sharing.[7]

These audits highlight the ongoing compliance risk associated with COVID-19 relief funds, even years after their initial distribution.

Patients Leaving Against Medical Advice

Medicare enrollees are leaving acute-care hospitals against medical advice (AMA) at steadily increasing rates, with the highest AMA rates occurring at lower-quality hospitals and among dual-eligible and mentally ill populations.[8] Hospitals should strengthen discharge-planning processes, documentation practices, and patient-engagement protocols, particularly for high-risk populations. Rising AMA rates signal potential quality-of-care vulnerabilities that carry both patient-safety and reimbursement-related compliance risk.

CMPs and Self-Disclosures

Emergency Medical Treatment and Labor Act (EMTALA)

EMTALA remained a significant compliance risk for hospitals in 2025. EMTALA requires hospitals with emergency departments to provide an appropriate medical screening examination and stabilizing treatment for individuals with emergency medical conditions, regardless of insurance coverage, and to ensure that transfers occur only when medically appropriate. In 2025, OIG resolved 13 EMTALA enforcement actions, underscoring continued focus on on-call coverage, transfer obligations, and psychiatric emergency care.

As one example, Baptist Medical Center South agreed to pay $290,000 to resolve allegations arising from three separate incidents in which the hospital failed to provide appropriate medical screening examinations or stabilizing treatment for psychiatric patients. In each case, patients left the emergency department—either by elopement or AMA—before receiving ordered psychiatric evaluations or stabilizing care. OIG alleged that hospital staff failed to adequately assess the patients' capacity to leave, communicate risks associated with departure, or ensure appropriate supervision and stabilization prior to discharge.

OIG's settlements highlight recurring EMTALA risk areas, including inadequate medical and psychiatric screening, failures to provide stabilizing treatment, improper reliance on telephonic consultations, inappropriate discharges or transfers, and failures to accept appropriate transfers despite having available capacity.

OIG's Provider Self-Disclosure Protocol Resolutions

In 2025, OIG resolved a significant volume of matters through its Provider Self-Disclosure Protocol (SDP), offering insight into recurring compliance risk areas for hospitals. While the SDP allows providers to resolve self-identified potential fraud with reduced penalties, participation requires timely disclosure, cooperation, and corrective action. The most common self-disclosures involved the employment of excluded individuals or unlicensed providers, AKS violations, and billing for services not provided.

OIG addressed a range of hospital-specific risks, including inpatient admissions that failed to meet the two-midnight rule, clinical research compliance deficiencies, upcoding, improper incident-to billing, and remote monitoring and telehealth services not furnished as claimed. These disclosures highlight the continued importance of exclusion screening, credentialing oversight, referral monitoring, and billing audits in high-risk service areas.

Hospital Compliance Takeaways

- Hospital financial relationships with physicians and vendors remain a high-risk area, particularly where compensation, subsidies, or services are not commercially reasonable, adequately documented, and actively monitored for AKS compliance.
- Quality-of-care and patient safety issues increasingly intersect with enforcement exposure, as underreported patient harm events, rising AMA discharges, and EMTALA deficiencies signal broader compliance vulnerabilities.
- PRF compliance remains an active enforcement concern and should be included in internal risk assessments.

- Self-disclosure resolutions reinforce the need for robust exclusion screening, credentialing oversight, referral monitoring, and targeted billing audits in high-risk service areas.

Skin Substitutes

Medicare Part B payments for skin substitutes surged to more than $10 billion over a two-year period, making skin substitutes one of the most acute fraud, waste, and abuse risk areas. In September 2025, the Office of Evaluation and Inspection (OEI) identified a sharp increase in Part B spending driven by a small number of products and providers, with billing patterns that departed from clinical norms.[9] OIG attributed this growth in part to aggressive marketing practices and limited clinical oversight, and noted two related criminal convictions involving a combined $1.2 billion in false or fraudulent claims.[10]

Vohra Wound Physicians agreed to pay $45 million to resolve allegations that it caused the submission of false claims for medically unnecessary surgical excisional debridement procedures and paid kickbacks to induce physicians to use specific products.[11] DOJ alleged that providers applied skin substitutes excessively and without proper documentation of medical necessity. The CIA required extensive monitoring of wound care practices, product utilization, and physician compensation arrangements.

The Centers for Medicare & Medicaid Services (CMS) changed its guidance by revising the payment methodology for skin substitutes to reduce financial incentives for overutilization, including limiting or restructuring separate Part B reimbursements for office-based and hospital outpatient settings and aligning payment more closely with clinical appropriateness and utilization controls.[12]

Skin Substitute Compliance Takeaways

- Medical necessity documentation is critical, particularly regarding wound characteristics and treatment history.
- Health IT systems are now an enforcement vector. DOJ and OIG are increasingly scrutinizing electronic health record configuration, clinical decision support tools, and automated documentation features that may drive utilization or constrain physician judgment, including the use of AI.
- CIA requirements signal expanded expectations around IT governance, internal controls, and independent review of technology-enabled clinical workflows.
- Data-driven enforcement is accelerating. OIG analytics and CMS' planned AI-supported utilization management oversight tools increase exposure for outlier billing patterns, even absent whistleblower involvement.

Technology

Technology-related enforcement signaled an expansion of provider risk, focusing on whether failures in data security, interoperability, and digital health compliance were material to federal health care payments under the FCA. OIG evaluations highlighted emerging compliance risks associated with

rapidly scaling technologies, including remote patient monitoring (RPM), while CMS and the Office of the National Coordinator for Health Information Technology (ONC) advanced enforcement of information blocking rules.

FCA Enforcement

Health Net Federal Services (HNFS), and it's corporate parent, Centene Corporation, a contractor administering the TRICARE program for the Defense Health Agency, agreed to pay $11.2 million to resolve FCA allegations arising from systemic cybersecurity failures.[13] DOJ alleged that HNFS falsely certified compliance with contractual cybersecurity requirements while failing to implement required security controls, thereby placing sensitive beneficiary data at risk. Although HNFS is not a health care provider, the settlement is highly relevant to hospitals and health systems because the government alleged falsely certifying compliance with security controls was material to payment.

Illumina agreed to pay $9.8 million to resolve FCA allegations that it sold genomic sequencing systems with cybersecurity vulnerabilities to federal agencies.[14] Specifically, DOJ alleged that Illumina sold devices with unresolved security flaws and failed to meet contractual and regulatory cybersecurity obligations, while continuing to submit claims or cause claims to be submitted to federal health care programs.

The settlement reflects a broader enforcement trend treating cybersecurity as a patient safety and program integrity issue, particularly where compromised systems could affect diagnostic accuracy or expose protected health information. For providers relying on complex medical devices and software, the case reinforces the importance of vendor oversight and cybersecurity due diligence.

Information Blocking

In 2025, HHS-OIG and ONC issued an enforcement alert addressing information blocking.[15] The alert emphasized that health IT developers, health information exchanges, health information networks, and entities offering certified health IT may be subject to civil monetary penalties for practices that interfere with the access, exchange, or use of electronic health information.

OIG's identified enforcement priorities focused on information blocking occurring over an extended period or that resulted in patient harm, disruption of patient care, or financial harm to federal health care programs. Information blocking enforcement represents a significant compliance risk area related to operations and governance. Compliance requires coordination among compliance, IT, health information management, and vendor management functions, as well as effective oversight of health IT vendors.

OIG Data Snapshot: Remote Patient Monitoring (RPM)

Medicare payments for RPM exceeded $500 million in 2024. OIG identified rapid growth in RPM utilization and spending and red flags, such as providers billing for RPM services without sufficient patient engagement, use of RPM in populations unlikely to meet coverage requirements, and reliance on third-party vendors with limited clinical oversight.[16]

RPM represents a significant developing enforcement risk, particularly where providers lack clear documentation of medical necessity, patient consent, and ongoing monitoring of technology and vendors.

Technology Compliance Takeaways

- Cybersecurity compliance can create FCA exposure, particularly where certifications or contractual representations are tied to payment.
- Vendor risk is provider risk. Oversight of device manufacturers and digital health vendors is increasingly critical.
- Information blocking enforcement is an OIG priority and should be included in risk assessments.
- Emerging technologies like RPM require guardrails around medical necessity, documentation, and vendor relationships.

Nursing Homes

Enforcement and oversight activity involving nursing homes in 2025 continued to reflect intense government concern about quality of care, resident safety, and financial integrity. DOJ FCA cases, OIG audits, and program evaluations consistently emphasized that failures in staffing, care planning, and incident reporting can create both patient harm and FCA exposure.

FCA Enforcement

In 2025, DOJ resolved multiple FCA cases involving nursing homes based on allegations that facilities provided substandard care. Across these matters, the government focused on systemic failures—such as chronic understaffing, inadequate care planning, poor infection control, and failure to prevent falls and pressure ulcers—that allegedly rendered claims false. These systemic failures are tantamount to services not rendered. Several resolutions included CIAs, reflecting OIG's continued emphasis on structural quality-of-care oversight and prevention rather than isolated instances of patient harm.

For example, Moroun Nursing Center of Detroit agreed to pay $4.5 million to resolve FCA allegations that it provided grossly substandard care to residents.[17] DOJ alleged that residents suffered from preventable pressure ulcers, infections, dehydration, and inadequate hygiene due to chronic understaffing and failure to follow care plans. The settlement included a five-year CIA requiring enhanced staffing oversight, quality-of-care monitoring, and independent reviews of resident care.[18] The CIA also imposed reporting obligations related to adverse events and quality metrics, reflecting OIG's emphasis on structural quality controls in long-term care settings.

OIG Audits and Evaluations

In one audit, OIG found that nearly all skilled nursing services provided at one facility failed to meet Medicare payment requirements.[19] Identified deficiencies included inadequate documentation, failure to meet skilled care criteria, and billing for services that did not require skilled nursing. The audit reinforces the importance of accurate care classification.

OIG and CMS evaluations in 2025 painted a sobering picture of systemic challenges in nursing home oversight. OIG concluded that CMS' Special Focus Facility program has not yielded lasting improvements in quality for chronically underperforming nursing homes.[20] Data showed persistent quality issues despite enhanced oversight.[21] OIG identified high rates of serious falls among Medicare-enrolled nursing home residents.[22] Nursing homes failed to report 43% of falls resulting in major injury or hospitalization, raising concerns about transparency and resident safety.[23]

Nursing Home Compliance Takeaways

- Systemic quality-of-care failures can create FCA liability, with DOJ treating chronic understaffing, inadequate care planning, and poor infection control as equivalent to services not rendered.
- Staffing and care planning deficiencies remain core enforcement triggers, particularly where preventable harms such as falls, pressure ulcers, and infections reflect breakdowns in basic resident care.
- Accurate care classification and documentation are critical to Medicare payment compliance, as OIG audits continue to identify billing for services that do not meet skilled nursing criteria.

Laboratories

DOJ's laboratory enforcement focused on medically unnecessary testing, kickback-tainted referrals, and improper relationships with marketers and telemedicine platforms. Some cases also included individual liability, underscoring heightened personal risk for lab owners and executives.

FCA Enforcement

Patients Choice Laboratories agreed to pay $9.62 million to resolve allegations that it performed tests without sufficient clinical justification and paid remuneration to induce referrals.[24] The FCA settlement included a CIA requiring claims reviews from an independent review organization, physician education, and oversight of referral relationships.

Genexe agreed to pay $6 million, with its owner also resolving individual liability, based on allegations that it paid kickbacks to telemedicine providers to generate lab orders.[25] DOJ alleged that the arrangement resulted in medically unnecessary testing reimbursed by FHCPs.

The former owner of True Health Diagnostics, Christopher Grottenthaler, agreed to pay $4.25 million to resolve allegations that he paid kickbacks to marketers disguised as consulting fees and waived copays and deductibles to induce referrals.[26] The case exemplifies DOJ's focus on individual accountability.

Laboratory Compliance Takeaways

- Medical necessity remains the central enforcement driver in laboratory FCA cases, particularly where testing lacks documented clinical justification.
- Referral relationships tied to marketing and telemedicine platforms present heightened AKS risk, especially when compensation is volume-based or linked to test ordering.
- Routine testing patterns can create red flags, even for common assays.

Pharmacy

Pharmacy enforcement reflected DOJ's focus on opioid dispensing, medical necessity, and adequate safeguards for pharmacy practices. Several high-profile cases—some years in the making—matured into significant resolutions, reinforcing that pharmacies remain squarely within the government's core enforcement portfolio.

FCA Enforcement

Walgreens agreed to pay up to $350 million to resolve allegations that it unlawfully filled opioid prescriptions that lacked a legitimate medical purpose and then submitted false claims to federal health care programs.[27] DOJ alleged that Walgreens pharmacists routinely ignored "red flags" indicating prescriptions were invalid, including high dosages, early refills, and combinations associated with abuse. The settlement included a CIA requiring Walgreens to implement enhanced controls over controlled substance dispensing, strengthen pharmacist decision-making authority, improve documentation of prescription reviews, and report opioid-related metrics to OIG.

CVS and its long-term care pharmacy subsidiary, Omnicare, were adjudicated liable for FCA damages and penalties totaling nearly $1 billion for dispensing drugs without valid prescriptions and failing to meet Medicare Part D requirements.[28] CVS indicated it plans to appeal the decision.

Pharmacy Compliance Takeaways

- Pharmacists are expected to exercise independent judgment, particularly for controlled substances.
- Long-term care pharmacy operations face heightened scrutiny due to scale and complexity.
- Dispensing failures—not just prescribing misconduct—can drive FCA liability. Pharmacies are expected to act as gatekeepers against diversion.

Physician Practices

Physician practices remained a focus of enforcement and oversight with FCA settlements, audits, and evaluations spanning multiple specialties. Across these actions, the government emphasized coding integrity, medical necessity, supervision, and the downstream impact of physician documentation on federal payment systems, particularly Medicare Advantage.

FCA Enforcement

Both large physician groups and individual practitioners reached FCA settlements. For example, Seoul Medical Group, a large independent physician association, agreed to pay over $62 million to resolve allegations that it submitted unsupported diagnosis codes to inflate Medicare Advantage risk scores[29]—highlighting the central role of physician documentation in diagnosis-driven payment models. At the individual level, a pain management physician, Dr. Kamal Kabakibou, and his practice resolved FCA and Controlled Substances Act allegations related to medically unnecessary testing and improper opioid prescribing, with a $3.5 million settlement accompanied by an integrity agreement.[30]

Audits and Evaluations by Specialty

To streamline discussion of specialty-specific audit and oversight activity, the table below summarizes key OIG findings by physician specialty during 2025. These audits signal areas of common documentation and medical necessity vulnerabilities across clinical disciplines.

OIG Audits Highlighting Provider Compliance Risk (2025)

Specialty	**Audit Focus**	**OIG Findings**	**OIG Report**
Eye Care	Same-day E/M and injections	Noncompliant billing and documentation	A-09-23-03014
Eye Care	Services in nursing facilities	Improper payments for noncovered services	A-05-24-00009
Podiatry	E/M services	Upcoding; insufficient documentation	A-09-22-03012
Podiatry	Routine foot care	Coverage noncompliance	OIG Routine Foot Care Audit
Dermatology	Same-day E/M and minor procedures	Continued audit scrutiny	A-04-21-04083
Anesthesia	Spinal pain management	At-risk payments	A-09-23-03013
Urology	Intermittent urinary catheters	Lack of medical necessity	A-09-22-03019

Physician Practice Compliance Takeaways

- Same-day billing remains a perennial audit target, even where compliance is achievable.
- Individual physicians face growing enforcement risk.
- Specialty-specific audits signal enforcement pipelines, not isolated findings.

Conclusion

Across sectors, DOJ and HHS-OIG targeted breakdowns in documentation, medical necessity, quality oversight, and internal controls—often relying on data analytics and operational metrics rather than novel legal theories. For providers, the message is less about new rules and more about sustained discipline. It is riskier for compliance programs to be siloed, reactive, or disconnected from clinical operations and technology governance.

As these priorities carry into 2026, providers that integrate compliance into day-to-day operations—and use their own data to identify emerging risk—will be better positioned to withstand continued enforcement scrutiny.

About the Authors

Lisa Re is a nationwide authority on health care fraud enforcement and compliance. She held key executive leadership roles during her twenty-year career at the U.S. Department of Health and Human Services (HHS) Office of Inspector General (OIG), including Assistant Inspector General for Legal Affairs and Acting Chief Counsel. Her practice focuses on health care regulatory and enforcement matters, particularly involving OIG investigations, compliance, and government oversight.

Lisa served as HHS's representative for False Claims Act cases and spent years coordinating with the U.S. Department of Justice on these matters. She led OIG's administrative litigation and exclusion program, established enforcement priorities, and oversaw OIG's self-disclosure protocol. Lisa was also responsible for OIG's compliance policy and Corporate Integrity Agreement (CIA) enforcement, helping to strengthen the agency's oversight of the pharmaceutical, biotech, and medical technology industries.

Lisa has deep expertise advising on complex issues and laws, such as the Anti-Kickback Statute, Civil Monetary Penalties law, Emergency Medical Treatment and Labor Act, Information Blocking, and the Exclusions Statute. As a compliance authority, she signed, negotiated, monitored, and enforced OIG's CIAs. This sophisticated knowledge helps clients establish compliance programs and identify vulnerabilities to protect health care organizations from fraud liability.

Lori Wright counsels clients on a broad range of regulatory and transactional matters in the health care industry, primarily focusing on health care regulatory matters related to the expansion and acquisition of provider entities. She has experience advising health care organizations, health care professionals and private equity firms on a variety of regulatory issues, including licensure and certification of health care facilities, corporate practice restrictions, Medicare and Medicaid program participation requirements, telehealth and telemedicine, and federal and state health care fraud, abuse and self-referral laws.

Lily Cao focuses her practice on a range of life sciences and health care matters. She counsels clients on regulatory, compliance, transactional, and legislative issues. Lily graduated *cum laude* from the University of California College of the Law, San Francisco, where she served as a health law research assistant and a teaching assistant. During law school, Lily also served as an extern at AHLA, an intern at a major medical device company, and an extern at two global law firms. Prior to attending law school, she worked as a health care practitioner and later transitioned into business and operational management roles in the medical device industry.

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