
Work Plan Part I: Medicare Part A and Part B

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Note: selected acronyms and abbreviations of terms, titles, organizations, and laws used in the Work Plan are spelled out in Appendix B.

Medicare Part A and Part B

Medicare Part A helps cover inpatient care in hospitals, including critical access hospitals, skilled nursing facilities (excepting custodial or long-term care), hospice care, and some home health care. Medicare Part B helps cover physicians' services and outpatient care. It also covers designated other medical services that Part A does not cover, such as some physical and occupational therapy services and home health care.

Historically, Medicare contractors that are known as fiscal intermediaries (FI) and carriers have handled Medicare's claims administration activities, with the FIs processing claims for Medicare Parts A and B for certain facilities (including hospitals and skilled nursing facilities (SNF) and the carriers processing claims for Medicare Part B (including for physicians', laboratories', and other services). The Centers for Medicare & Medicaid Services (CMS) also engages contractors that perform specific fee-for-service (FFS) business functions. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 911, CMS is implementing a Medicare contracting reform initiative that will replace FIs and carriers with Medicare Administrative Contractors (MAC) that will process both Part A and Part B claims. The reform plan includes specialty MACs that will service suppliers of durable medical equipment (DME).

Descriptions of our work in progress and planned reviews of Medicare Part A and Part B payments and services for fiscal year (FY) 2011 follow.

Hospitals

Part A Hospital Capital Payments

We will review Medicare inpatient capital payments. Capital payments reimburse a hospital's expenditures for assets such as equipment and facilities. The basic methodology for determining capital prospective rates is found in the Code of Federal Regulations (CFR) at 42 CFR § 412.308. We will determine whether capital payments to hospitals are appropriate. *(OAS; W-00-09-35300; W-00-10-35300; various reviews; expected issue date: FY 2011; work in progress)*

Provider-Based Status for Inpatient and Outpatient Facilities

We will review cost reports of hospitals claiming provider-based status for inpatient and outpatient facilities. Pursuant to 42 CFR § 413.65(d), Medicare may permit hospitals that own and operate multiple provider-based facilities or departments in different sites to operate as a single entity, so long as specific requirements are met. Hospitals that receive this "provider-based status" may receive higher reimbursement when they include the costs of a provider-based entity on their cost reports. Freestanding facilities may also benefit from enhanced

disproportionate share hospital (DSH) payments, upper payment limit (UPL) payments, or graduate medical education payments for which they would not normally be eligible. Provider-based status for outpatient clinics may increase coinsurance liability for Medicare beneficiaries. We will determine the appropriateness of the provider-based designation and the potential impact on the Medicare program and its beneficiaries of hospitals improperly claiming provider-based status for inpatient and outpatient facilities.

(OAS; W-00-10-35424; W-00-11-35424; various reviews; expected issue date: FY 2011; work in progress)

Hospital Payments for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System

We will review the appropriateness of payments for nonphysician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at acute care hospitals. Pursuant to the Social Security Act, § 1886(a)(4), and 42 CFR § 412.2, inpatient prospective payment system (IPPS) payments to hospitals for inpatient stays are payment in full for hospitals' operating costs and hospitals generally receive no additional payments for nonphysician services. For nonphysician services provided to inpatients by entities under arrangements with the hospitals, the Social Security Act, §§ 1862(a)(14) and 1861(w)(1), as interpreted by CMS in its FY 1983 IPPS final rule, prohibits submissions of any additional claims to Part B. Section 1886(a)(4) prohibits separate payments for outpatient diagnostic services and admission-related nondiagnostic services rendered up to 3 days before the dates of admission. Prior Office of Inspector General (OIG) work in this area found significant numbers of improper claims.

(OAS; W-00-10-35436; various reports; expected issue date: FY 2011; work in progress)

Noninpatient Prospective Payment System Hospital Payments for Nonphysician Outpatient Services

We will review the appropriateness of payments for nonphysician outpatient services that were provided to beneficiaries shortly before or during Medicare Part A-covered stays at non-IPPS hospitals. Pursuant to the Social Security Act, § 1886(a)(4), payments to non-IPPS hospitals for inpatient claims should include diagnostic services and other services related to admission provided during 1 day immediately preceding the date of the patient's admission. For nonphysician services provided to inpatients, CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 3, §§ 40.3 B and 40.3 C, prohibits submissions of additional claims to Part B for outpatient diagnostic services and admission-related nondiagnostic services rendered up to 1 day before and on the date of admission.

(OAS; W-00-11-35450; various reviews; expected issue date: FY 2011; new start)

Critical Access Hospitals

We will review payments to critical access hospitals (CAH). Pursuant to the Social Security Act, §§ 1814(l)(1) and 1834(g), CAHs are generally paid 101 percent of the reasonable costs of providing covered CAH services. We will determine whether CAHs have met the CAH

designation criteria in the Social Security Act, § 1820(c)(2)(B), and conditions of participation (CoP) at 42 CFR pt. 485, subpart F, and whether payments to CAHs were in accordance with Medicare requirements.

(OAS; W-00-10-35101; W-00-11-35101; various reviews; expected issue date: FY 2011; work in progress)

Medicare Excessive Payments

We will review Medicare claims with high payments to determine whether they were appropriate. Our prior work has shown that claims with unusually high payments may be incorrect for various reasons. Pursuant to CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 20.4, hospitals are required to report units of service as the number of times that a service or procedure was performed. Our work will include certain outpatient claims in which payments exceeded charges and selected Healthcare Common Procedure Coding System (HCPCS) codes for which billings appear to be aberrant. We will also review the effectiveness of the claims processing edits used to identify excessive payments.

(OAS; W-00-10-35518; W-00-11-35518; various reviews; expected issue date: FY 2011; work in progress)

Medicare Disproportionate Share Payments

We will review Medicare DSH payments to hospitals. Pursuant to the Social Security Act, § 1886(d)(5)(F)(i)(I), Medicare makes additional payments to acute care hospitals that serve a significantly disproportionate number of low-income patients. Medicare DSH payments have been steadily increasing. OIG will determine whether these payments were in accordance with Medicare methodology in the Social Security Act, § 1886(d)(5)(F)(v-vii). We will also examine the total amounts of uncompensated care costs that hospitals incur.

(OAS; W-00-10-35402; W-00-11-35402; various reviews; expected issue date: FY 2011; work in progress)

Medicare Outlier Payments

We will review Medicare outlier payments to determine whether CMS appropriately reconciled the payments. Outliers are additional payments made for beneficiaries who incur unusually high costs. Pursuant to Federal regulations at 42 CFR § 412.84(i)(4), outlier payment reconciliations must be based on the most recent cost-to-charge ratio from the cost report to properly determine outlier payments. Outlier payments also may be adjusted to reflect the time value of money for overpayments and underpayments.

(OAS; W-00-11-35451; various reviews; expected issue date: FY 2011; new start)

Duplicate Graduate Medical Education Payments

We will review provider data from CMS's Intern and Resident Information System (IRIS) to determine whether duplicate graduate medical education payments have been claimed. Medicare pays teaching hospitals for direct graduate medical education (DGME) and indirect medical education (IME) costs. Federal regulations at 42 CFR §§ 413.78(b) and 412.105(f)(1)(iii)

specify that in the calculation of payments for DGME and IME costs, no intern or resident may be counted by the Medicare program as more than one full-time-equivalent (FTE) employee. IRIS's primary purpose is to ensure that no intern or resident is counted as more than one FTE. If duplicate payments were claimed, we will determine which payment was appropriate. We will also assess the effectiveness of IRIS in preventing providers from receiving payments for duplicate graduate medical education costs.

(OAS; W-00-09-35432; W-00-10-35432; W-00-11-35432; various reviews; expected issue date: FY 2011; work in progress)

Hospital Occupational Mix Data Used To Calculate Inpatient Hospital Wage Indexes

We will determine whether hospitals reported occupational-mix data used to calculate inpatient wage indexes in compliance with Medicare regulations. Hospitals must accurately report data every 3 years on the occupational mix of their employees in accordance with the Social Security Act, § 1886 (d)(3)(E). CMS uses data from the occupational-mix survey to construct an occupational-mix adjustment to its hospital wage indexes. Accurate wage indexes are essential elements of the Medicare prospective payment system (PPS) for hospitals. We will determine the effect on the Medicare program of inaccurate reporting of occupational-mix data.

(OAS; W-00-11-35452; various reviews; expected issue date: FY 2011; new start)

Medicare Secondary Payer/Other Insurance Coverage

We will review Medicare payments for beneficiaries who have other insurance. Pursuant to the Social Security Act, § 1862(b), Medicare payments for such beneficiaries are required to be secondary to certain types of insurance coverage. We will assess the effectiveness of procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage. For example, we will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amounts.

(OAS; W-00-11-35317; various reviews; expected issue date: FY 2011; new start)

Reliability of Hospital-Reported Quality Measure Data

We will review hospitals' controls for ensuring the accuracy of data related to quality of care that they submit to CMS for Medicare reimbursement. The Social Security Act, § 1886(b)(3)(B)(vii), requires that hospitals report quality measures for a set of 10 indicators established by the Secretary as of November 1, 2003. Section 501(b) of the MMA established a reduction in payments of 0.4 percent to hospitals that did not report quality measures to CMS. The Social Security Act, § 1886(b)(3)(viii), as added by the Deficit Reduction Act of 2005 (DRA), § 5001(a), expanded the payment reduction to 2 percent effective at the beginning of FY 2007. We will determine whether hospitals have implemented sufficient controls to ensure that their quality measurement data are valid.

(OAS; W-00-11-35438; various reviews; expected issue date: FY 2011; new start)

Hospital Readmissions

We will review Medicare claims to determine trends in the number of hospital readmission cases. Based on prior OIG work, CMS implemented an edit in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day. Pursuant to CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 3, § 40.2.5, if a same-day readmission occurs for symptoms related to or for evaluation or management of the prior stay's medical condition, the hospital is entitled to only one diagnosis-related group (DRG) payment and should combine the original and subsequent stays into a single claim. Providers are permitted to override the edit in certain situations. We will test the effectiveness of the edit. We will also determine the extent of oversight of readmission cases. Pursuant to the Social Security Act, § 1154(a)(13), quality improvement organizations (QIO) are required to review hospital readmission cases to determine whether the hospital services met professional standards of care. A readmission is defined as a case in which the beneficiary is readmitted to a hospital less than 31 days after being discharged from a hospital.

(OAS; W-00-10-35439; W-00-11-35439; various reviews; expected issue date: FY 2011; work in progress)

Hospital Admissions With Conditions Coded Present-on-Admission

We will review Medicare claims to determine which types of facilities are most frequently transferring patients with certain diagnoses that were coded as being present when patients were admitted, referred to as present on admission (POA). Pursuant to the Social Security Act, § 1886(d)(4)(D), and CMS's *Change Request 5679* (Pub. 100-20, One-Time Notification, Transmittal 289), acute care hospitals are required to report on their Medicare claims which diagnoses were present when patients were admitted. For certain diagnoses specified by CMS, hospitals receive a lower payment if the specified diagnoses were acquired in the hospital. We will also determine whether specific providers transferred a high number of patients to hospitals with POA diagnoses.

(OAS; W-00-10-35500; W-00-11-35500; various reviews; expected issue date: FY 2011; work in progress)

Early Implementation of Medicare's Policy for Hospital-Acquired Conditions

We will review the early implementation of CMS's hospital-acquired conditions (HAC) policy. Pursuant to section 5001(c) of the DRA, CMS implemented the HAC policy on October 1, 2008. The HAC policy prevents additional payment under Medicare's hospital IPPS for certain conditions or complications that are determined to be reasonably preventable. We will review Medicare claims data to identify the number of beneficiary stays associated with HACs and determine their impact on reimbursement. We will also verify the accuracy of POA indicators, which are used for identifying HACs.

(OEI; 06-09-00310; expected issue date: FY 2011; work in progress)

Responses to Adverse Events in Hospitals by Medicare Oversight Entities

We will review responses of State survey-and-certification agencies, Medicare accreditors, and CMS to allegations of adverse events in hospitals. An “adverse event” is defined as harm to a patient as a result of medical care. Various Medicare oversight entities have authority to investigate adverse events in hospitals to determine whether those hospitals have taken corrective actions and are in compliance with Medicare standards. We will identify and analyze potential overlaps, conflicts, and gaps in responses and identify opportunities for Medicare oversight entities to improve the quality of oversight and responses to adverse events.

(OEI; 01-08-00590; expected issue date: FY 2011; work in progress)

Hospital Reporting for Adverse Events

We will review the type of information hospitals’ internal incident-reporting systems capture about adverse events. Most hospitals have incident-reporting systems that enable medical and hospital staff members to report information about patient safety incidents when they occur and to use reported information to prevent recurrence, hold staff members accountable, and notify families. Using data collected for a 2010 OIG study examining the national incidence of adverse events among hospitalized Medicare beneficiaries, we will determine the extent to which hospital systems captured adverse events and reported the information to external patient-safety oversight entities.

(OEI; 06-09-00091; expected issue date: FY 2011; work in progress)

Hospital Reporting for Restraint- and Seclusion-Related Deaths

We will review hospital-reported restraint and seclusion-related deaths to determine the volume of reports and their outcome. The Patient’s Rights Hospital Condition of Participation rule at 42 CFR § 482.13(g) requires that hospitals report to CMS each death that occurs while a patient is in restraint or seclusion, as well as each death that occurs within 24 hours after a patient has been removed from restraint or seclusion. CMS regional staff members determine whether a death requires an investigation by a State agency. A 2006 OIG report found problems with the restraint- and seclusion-reporting process and stated that the reporting requirements and reporting process may hinder the effectiveness of CMS’s and State agencies’ efforts to identify and respond to restraint- and seclusion-related deaths. We will also determine the outcome of State investigations of restraint and seclusion deaths and the action the State agencies took against hospitals.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Brachytherapy Reimbursement

We will review payments for brachytherapy, a form of radiotherapy where a radiation source is placed inside or next to the area requiring treatment, to determine whether the payments are in compliance with Medicare requirements. Pursuant to the Social Security Act, § 1833 (t)(16)(C), as amended by the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), § 142, Medicare pays for radioactive source devices used in treatment of certain forms of cancer.

(OAS; W-00-10-35520; W-00-11-35520; various reviews; expected issue date: FY 2011; work in progress)

Payments for Diagnostic Radiology Services in Hospital Emergency Departments

We will review Medicare Part B paid claims and medical records for interpretations and reports of diagnostic radiology services (x-rays, CTs, and MRIs) performed in hospital emergency departments to determine the appropriateness of payments. Interpretations and reports furnished by physicians are reimbursed according to the Medicare Physician Fee Schedule (MPFS) provided that the conditions for payment for radiology services at 42 CFR §§ 415.102(a) and 415.120 are met. In its March 2005 testimony before Congress, the Medicare Payment Advisory Commission (MedPAC), reported concerns about the increasing cost of imaging services for Medicare beneficiaries and potential overuse of diagnostic radiology services. In 2008, Medicare reimbursed physicians about \$227 million for imaging interpretations performed in emergency departments. We will determine whether diagnostic radiology interpretations and reports contributed to the diagnoses and treatment of beneficiaries receiving care in emergency departments.

(OEI; 07-09-00450; expected issue date: FY 2011; work in progress)

Hospitals' Compliance With Medicare Conditions of Participation for Intensity-Modulated and Image-Guided Radiation Therapy Services

We will review hospitals' compliance with Medicare requirements concerning the safety and quality of intensity modulated radiation therapy (IMRT) and image-guided radiation therapy (IGRT) services. Pursuant to 42 CFR § 482.26, therapeutic radiological services, such as IMRT and IGRT, must meet professionally approved standards for safety and personnel qualification. Hospitals must maintain appropriate radiologic services to ensure safety for patients and personnel in compliance with Medicare CoP. We will also assess CMS's oversight of IMRT and IGRT services provided in hospitals.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Inpatient and Outpatient Hospital Claims for the Replacement of Medical Devices

We will determine whether hospitals submitted inpatient and outpatient claims that included procedures for the insertion of replacement medical devices in compliance with Medicare regulations. The Social Security Act, §1862(a)(2), excludes from Medicare coverage an item or a service for which neither the beneficiary nor anyone on his or her behalf has an obligation to pay. Medicare is not responsible for the full cost of the replaced medical device if the hospital receives a partial or full credit from the manufacturer either because the manufacturer recalled the device or because the device is covered under warranty. Hospitals are required to use modifiers on their inpatient and outpatient claims when they receive credit from the manufacturer of 50 percent or more for a replacement device.

(OAS; W-00-10-35516; W-00-11-35516; various reviews; expected issue date: FY 2011; work in progress)

Observation Services During Outpatient Visits

We will review Medicare payments for observation services provided during outpatient visits in hospitals. The Social Security Act, §§ 1832(a) and 1833(t), provides for Part B coverage of hospital outpatient services and reimbursement for such services under the Hospital Outpatient Prospective Payment System (OPPS). CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 290, provides the billing requirements. We will assess whether and to what extent hospitals' use of observation services affects the care Medicare beneficiaries receive and their ability to pay out-of-pocket expenses for health care services.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Hospital Inpatient Outlier Payments

We will review hospital inpatient outlier payments. Medicare typically reimburses hospitals for inpatient services based on a predetermined per-discharge amount, regardless of the actual costs incurred. The Social Security Act, § 1886(d)(5)(A)(ii), allows Medicare to pay hospitals supplemental, or outlier, payments for patients incurring extraordinarily high costs. In 2009, outlier payments represented about 5 percent of total Medicare inpatient payments, or about \$6 billion per year. Recent whistleblower lawsuits have resulted in millions of dollars in settlements from hospitals charged with inflating Medicare claims to qualify for outlier payments. We will examine trends of outlier payments nationally and identify characteristics of hospitals with high or increasing rates of outlier payments.

(OEI; 06-10-00520; expected issue date: FY 2011; work in progress)

Inpatient Rehabilitation Facility Transmission of Patient Assessment Instruments

We will determine whether inpatient rehabilitation facilities (IRF) received reduced payments for claims with patient assessment instruments that were transmitted to CMS's National Assessment Collection Database more than 27 days after the beneficiaries' discharges. The patient assessment instrument is used to gather data to determine payment for each Medicare patient admitted to an IRF. Federal regulations for IRF payments at 42 CFR § 412.614(d)(2) provide that if patient assessments are not encoded and transmitted within defined time limits, payments be reduced. If an IRF transmits the instrument more than 27 calendar days from (and including) the beneficiary's discharge date, the IRF's payment rate should be reduced by 25 percent.

(OAS; W-00-10-35522; various reviews; expected issue date: FY 2011; work in progress)

Home Health Agencies

Part B Payments for Home Health Beneficiaries

We will review Part B payments for services and medical supplies provided to beneficiaries in home health episodes. Most services and nonroutine medical supplies furnished to Medicare beneficiaries during home health episodes are included in the home health agency (HHA) prospective payments. The Social Security Act, §§ 1832(a)(1) and 1842(b)(6)(F), require that in

the case of home health services furnished under a plan of care of an HHA, payment for those services be to the HHA, including payment for services and supplies provided under arrangements by outside suppliers. We will identify Part B payments to outside suppliers for services and medical supplies that are included in the HHA prospective payment and examine the adequacy of controls established to prevent inappropriate Part B payments for services and medical supplies.

(OAS; W-00-09-35418; W-00-10-35108; W-00-11-35418; various reviews; expected issue date: FY 2011; work in progress)

Home Health Agencies' Claims for Medicare Home Health Resource Groups

We will review Medicare claims submitted by HHAs to determine the extent to which the claims meet Medicare coverage requirements. Federal regulations at 42 CFR § 409.42 provide that beneficiaries receiving home health services must (1) be homebound; (2) need intermittent skilled nursing care, physical or speech therapy, or occupational therapy; (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician. The Social Security Act, § 1895, governs the payment basis and reimbursement for claims submitted by HHAs. On a prospective basis, Medicare reimburses for home health episodes using a system that categorizes beneficiaries into groups that are based on care and resource needs and that are referred to as Home Health Resource Groups (HHRGs). HHRGs are calculated using beneficiary assessment data collected by an HHA, and each HHRG has an assigned weight that affects the payment rate. We will assess the accuracy of HHRGs submitted for Medicare home health claims in 2008 and identify characteristics of miscoded HHRGs.

(OEI; 01-08-00390; expected issue date: FY 2011; work in progress)

Oversight of Home Health Agency Outcome and Assessment Information Set Data

We will review CMS's oversight of Outcome and Assessment Information Set (OASIS) data submitted by Medicare-certified HHAs. Federal regulations at 42 CFR § 484.55 require HHAs to conduct accurate comprehensive patient assessments that include OASIS data items and submit the data to CMS. OASIS data reflect HHAs' performance in helping patients to regain or maintain their ability to function and perform activities of daily living. OASIS data also include measures of physical status and use of services, such as hospitalization or emergent care. CMS has used OASIS data for its HHA PPS since 2000; began posting OASIS-based quality performance information on its Home Health Compare Web site in the fall of 2003; and conducted a home health pay-for-performance demonstration based on OASIS data during 2008 and 2009. We will review CMS's process for ensuring that HHAs submit accurate and complete OASIS data.

(OEI; 01-10-00460; expected issue date: FY 2011; work in progress)

Home Health Prospective Payment System Controls

We will review compliance with various aspects of the home health PPS, including billings for the appropriate location of the services provided. Pursuant to the Social Security Act, § 1895,

the home health PPS was implemented in October 2000. Since that time, total payments to HHAs have increased substantially from \$8.5 billion in 2000 to \$16.4 billion in 2008. We will also analyze various trends in HHA activities, including the number of claims submitted to Medicare, the number of visits provided to beneficiaries, arrangements with other facilities, and ownership information.

(OAS; W-00-11-35501; various reviews; expected issue date: FY 2011; new start)

Home Health Agency Profitability

We will review cost report data to analyze HHA profitability trends under the home health PPS to determine whether the payment methodology should be adjusted. The Social Security Act, § 1895, added by the Balanced Budget Act of 1997 (BBA), § 4603, requires a PPS for home health services. Since the PPS was implemented in October 2000, HHA expenditures have significantly increased. We will examine various trends, including profitability trends in Medicare and the overall profitability trends for freestanding and hospital-based HHAs.

(OAS; W-00-10-35428; various reviews; expected issue date: FY 2011; work in progress)

Medicare Home Health Agency Enrollment

We will review the program integrity efforts of CMS, its contractors, and State agencies during the HHA enrollment process. Pursuant to 42 CFR part 424, subpart P, each HHA provider must submit an accurate and complete enrollment application to CMS and adhere to a series of requirements to participate in the Medicare program. Previous work by OIG found that DME suppliers omitted or provided inaccurate information on enrollment applications, which resulted in improper enrollment, and that these suppliers were often associated with HHAs through shared owners and/or managers. We will determine whether the program integrity efforts of CMS, its contractors, and States identify and prevent the enrollment of questionable HHA applicants.

(OEI; 06-10-00400; expected issue date: FY 2011; work in progress)

Nursing Facilities

Medicare Part A Payments to Skilled Nursing Facilities

We will review the extent to which payments to SNFs meet Medicare coverage requirements. The Social Security Act, § 1888(e), establishes the amount paid to SNFs for all covered services. Medicare pays Part A SNF stays using a system that categorizes each beneficiary into a group based on care and resource needs. The groups are referred to as Resource Utilization Groups (RUGs). In a prior report, OIG found that 26 percent of claims had RUGs that were not supported by patients' medical records. The percentage represented \$542 million in potential overpayments for FY 2002. We will conduct a medical review to determine whether claims were medically necessary, sufficiently documented, and coded correctly during calendar year (CY) 2009.

(OEI; 02-09-00200; expected issue date: FY 2012; work in progress)

Medicare Requirements for Quality of Care in Skilled Nursing Facilities

We will review how SNFs have addressed certain Federal requirements related to quality of care. We will determine the extent to which SNFs (1) developed plans of care based on assessments of beneficiaries, (2) provided services to beneficiaries in accordance with the plans of care, and (3) planned for beneficiaries' discharges. Pursuant to the Social Security Act, §§ 1819(b)(3) and 1919(b)(3), nursing homes participating in the Medicare or Medicaid program are required to use the Resident Assessment Instrument (RAI) to assess each nursing home resident's strengths and needs. Prior OIG reports revealed that about a quarter of residents' needs for care, as identified through the RAI, were not reflected in care plans and that nursing home residents did not receive all the psychosocial services identified in care plans. We will also review SNFs' use of the RAI to develop nursing home residents' plans of care.

(OEI; 02-09-00201; expected issue date: FY 2012; work in progress)

Assessment and Monitoring of Nursing Home Residents Receiving Atypical Antipsychotic Drugs

We will review the extent to which nursing facilities comply with assessment and care-planning requirements for residents receiving atypical antipsychotic drugs. Federal regulations at 42 CFR § 483.20 require nursing facilities to develop resident care plans based on periodic resident assessments. Facilities are required to use the Minimum Data Set (MDS), a standardized assessment tool that includes measures of a resident's health and functional status. Previous OIG studies have found that some MDS data items were inaccurate. We will also examine the extent to which nursing homes used CMS's Resident Assessment Protocol for Psychotropic Drugs to develop residents' care plans.

(OEI; 07-08-00151; expected issue date: FY 2011; work in progress)

Oversight of Poorly Performing Nursing Homes

We will review CMS's and States' use of enforcement measures to determine their impact on improving the quality of care that beneficiaries received in poorly performing nursing homes and evaluate the performance of these nursing homes. The Social Security Act, §§ 1819(g) and 1864, established a survey-and-certification process, including an enforcement process, to ensure that nursing homes meet Federal standards for participation in the Medicare and Medicaid programs. We will examine enforcement decisions resulting from survey-and-certification (S&C) inspections, and actions taken by CMS and States. We will also determine the extent to which CMS and States follow up to ensure that poorly performing nursing homes implement plans of correction.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Hospitalizations of Nursing Home Residents

We will review the extent of hospitalizations of Medicare beneficiaries residing in nursing homes. Hospitalizations of nursing home residents are costly to the Medicare program and may be indicative of quality-of-care problems at nursing homes. A 2007 OIG study found that 35 percent of hospitalizations during a SNF stay were caused by poor quality of care or

unnecessary fragmentation of services. We will also assess CMS's oversight of nursing homes whose residents have high rates of hospitalization.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Nursing Home Emergency Preparedness and Evacuations During Selected Natural Disasters

We will review nursing homes' emergency plans and emergency preparedness deficiencies cited by State surveyors to determine the sufficiency of the nursing homes' plans and their implementation of the plans. Federal regulations at 42 CFR § 483.75(m), require that Medicare- and Medicaid-certified nursing homes have plans and procedures to meet all potential emergencies and train all employees in these emergency procedures. In 2006, OIG reported that nursing homes in certain Gulf States had plans that lacked a number of provisions suggested by emergency preparedness experts and that staff members did not always follow emergency plans. We will describe the experiences of selected nursing homes, including challenges, successes, and lessons learned, when they implemented their plans during recent disasters, such as hurricanes, floods, and wildfires.

(OEI; 06-09-00270; expected issue date: FY 2011; work in progress)

Criminal Background Checks for Nursing Facility Employees

We will determine whether and the extent to which nursing facilities have employed individuals who have criminal convictions. Pursuant to the Social Security Act, §§ 1819(b)(2) and 1919(b)(2), nursing facilities participating in the Medicare and Medicaid programs are required to provide services that maintain the dignity and well-being of all nursing home residents. We will categorize the types of crimes, if any are found, for which nursing facilities' employees have been convicted. We will also identify the number of States requiring criminal background checks.

(OEI; 07-09-00110; expected issue date: FY 2011; work in progress)

Program for National and State Background Checks for Long-Term-Care Employees

We will review the program of national and State background checks for prospective long-term-care employees mandated by the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act), § 6201, which requires the Secretary of HHS to implement a nationwide program to identify efficient, effective, and economical procedures for long-term-care facilities or providers to conduct background checks on prospective employees who will have direct patient access. The Affordable Care Act requires OIG to evaluate the program, to include a review of the procedures implemented by participating States for long-term-care facilities or providers to conduct background checks and an assessment of the costs of conducting such background checks.

(OEI; 07-10-00420; expected issue date: FY 2012; work in progress)

Medicare Part B Services During Non-Part A Nursing Home Stays: 2008 Overview

We will review the extent of Part B services provided to nursing home residents whose stays are not paid for under Medicare's Part A SNF benefit. Unlike Part B services provided during a Part A SNF stay, most of which must be billed to Medicare directly by the SNF in accordance with consolidated billing requirements, most Part B services provided during a non-Part A stay may be billed directly by suppliers and other providers. In repealing consolidated billing provisions that would have applied to non-Part A SNF stays, Congress directed OIG in the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), § 313, to monitor these services for abuse. We will also assess patterns of billing for Part B services among nursing homes and providers.

(OEI; 06-07-00580; expected issue date: FY 2011; work in progress)

Other Providers and Suppliers

Hospice Utilization in Nursing Facilities

We will review Medicare Part A hospice claims and data from the MDS to describe hospice utilization in nursing facilities. We will examine the characteristics of nursing facilities with high utilization patterns of Medicare hospice care and the characteristics of the hospices that serve them. The Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) created the Medicare hospice benefit for eligible beneficiaries under Medicare Part A. In a recent report, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, which is an independent Congressional agency established by the Balanced Budget Act of 1997 to advise Congress on issues affecting the Medicare program, has noted that hospices and nursing facilities have incentives to admit patients likely to have long stays. We will also assess the business relationships between nursing facilities and hospices and assess the marketing practices and materials of hospices associated with high utilization patterns.

(OEI; 02-10-00070; expected issue date: FY 2011; work in progress)

Services Provided to Hospice Beneficiaries Residing in Nursing Facilities

We will review the services that hospices and nursing facilities provide to hospice beneficiaries residing in nursing facilities, including services by hospice-based home health aides. Federal regulations address Medicare CoPs for hospice at 42 CFR part 418, and SNF requirements at 42 CFR 483. We will review hospice and nursing facility medical records, including plans of care. We will determine the extent to which hospices and nursing facilities coordinate care and identify service and payment arrangements between them. We will also assess the appropriateness of hospices' general inpatient care claims.

(OEI; 02-10-00490; expected issue date: FY 2012; work in progress)

Place-of-Service Errors

We will review physician coding of place of service on Medicare Part B claims for services performed in ambulatory surgical centers (ASC) and hospital outpatient departments. Federal regulations at 42 CFR § 414.32 provide for different levels of payments to physicians depending on where the services are performed. Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC. We will determine whether physicians properly coded the places of service on claims for services provided in ASCs and hospital outpatient departments.

(OAS; W-00-09-35113; W-00-10-35113; various reviews; expected issue date: FY 2011; work in progress)

Ambulatory Surgical Center Payment System

We will review the appropriateness of the methodology for setting ASC payment rates under the revised ASC payment system. Section 626(b) of the MMA requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. We will examine changes to the revised ASC payment system and the rate-setting methodology used to calculate ASC payment rates.

(OAS;; W-00-10-35423; W-00-11-35423; various reviews; expected issue date: FY 2011; work in progress)

Coding of Evaluation and Management Services

We will review evaluation and management (E&M) claims to identify trends in the coding of E&M services. Medicare paid \$25 billion for E&M services in 2009, representing 19 percent of all Medicare Part B payments. Pursuant to CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1, providers are responsible for ensuring that the codes they submit accurately reflect the services they provide. E&M codes represent the type, setting, and complexity of services provided and the patient status, such as new or established. We will review E&M claims to determine whether coding patterns vary by provider characteristics.

(OEI; 04-10-00180; expected issue date: FY 2011; work in progress)

Payments for Evaluation and Management Services

We will review the extent of potentially inappropriate payments for E&M services and the consistency of E&M medical review determinations. CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1 instructs providers to "select the code for the service based upon the content of the service" and says that "documentation should support the level of service reported." Medicare contractors have noted an increased frequency of medical records with identical documentation across services. We will also review multiple E&M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments.

(OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2012; work in progress)

Evaluation and Management Services During Global Surgery Periods

We will review industry practices related to the number of E&M services provided by physicians and reimbursed as part of the global surgery fee. CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 40, contains the criteria for the global surgery policy. Under the global surgery fee concept, physicians bill a single fee for all of their services that are usually associated with a surgical procedure and related E&M services provided during the global surgery period. We will determine whether industry practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was developed in 1992.

(OAS; W-00-09-35207; various reviews; expected issue date: FY 2011; work in progress)

Medicare Payments for Part B Imaging Services

We will review Medicare payments for Part B imaging services. Physicians are paid for services pursuant to the Medicare physician fee schedule, which covers the major categories of costs, including the physician professional cost component, malpractice costs, and practice expense. The Social Security Act, § 1848(c)(1)(B), defines "practice expense" as the portion of the resources used in furnishing the service that reflects the general categories of expenses, such as office rent, wages of personnel, and equipment. For selected imaging services, we will focus on the practice expense components, including the equipment utilization rate. We will determine whether Medicare payments reflect the expenses incurred and whether the utilization rates reflect industry practices.

(OAS; W-00-11-35219; various reviews; expected issue date: FY 2011; new start)

Billing of Portable X-Ray Suppliers

We will review providers of portable x-ray services with unusual claims patterns and identify Medicare claims that are questionable. Payment for the services provided by portable x-ray suppliers are governed by Federal regulations at 42 CFR § 486.100 through § 486.110. CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 13, § 90, says that diagnostic imaging services furnished by portable x-ray suppliers have as many as four components. In addition to paying suppliers for the technical and professional components of a test, Medicare pays these suppliers a setup component and transportation component. We will examine the billing patterns of portable x-ray suppliers to identify those that merit additional scrutiny.

(OEI; 12-10-00190; expected issue date: FY 2011; work in progress)

Services Performed by Clinical Social Workers

We will review services furnished by clinical social workers (CSW) to inpatients of Medicare participating hospitals or SNFs to determine whether the services were separately billed to Medicare Part B. Federal regulations at 42 CFR § 410.73(b)(2) describe services performed by CSWs that may not be billed as CSW services under Medicare Part B when provided to inpatients of certain facilities. We will examine Medicare Part A and Part B claims with overlapping dates of service to determine whether services performed by CSWs

in inpatient facilities were separately billed to Medicare Part B.
(OAS; W-00-11-35405; various reviews; expected issue date: FY 2011; new start)

Partial Hospitalization Program Services

We will review the appropriateness of Medicare payments for partial hospitalization program (PHP) psychiatric services. The Social Security Act, § 1832(a)(2)(J), provides for coverage of PHP services, and conditions for payment are in CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 260, and at 42 CFR §§ 410.43 and 424.24(e). A PHP is an intensive outpatient program of psychiatric services that hospitals may provide to individuals in lieu of inpatient psychiatric care. The program is to provide individuals who have mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment involving nurses, psychiatrists, psychologists, and social workers. Medicare spending for PHP services has increased over the years. We will determine whether Medicare payments for PHP psychiatric services in hospital outpatient departments and freestanding community mental health centers met Medicare requirements based on documentation supporting psychiatric services, including patient plans of care, and physician supervision and certification requirements.

(OAS; W-00-11-35453; various reviews; expected issue date: FY 2011; new start)

Outpatient Physical Therapy Services Provided by Independent Therapists

We will review outpatient physical therapy services provided by independent therapists to determine whether they are in compliance with Medicare reimbursement regulations. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." CMS's *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 15, § 220.3, contains documentation requirements for therapy services. Previous OIG work has identified claims for therapy services provided by independent physical therapists that were not reasonable, medically necessary, or properly documented. Focusing on independent therapists who have a high utilization rate for outpatient physical therapy services, we will determine whether the services that they billed to Medicare were in accordance with Federal requirements.

(OAS; W-00-11-35220; various reviews; expected issue date: FY 2011; new start)

Questionable Billing for Medicare Outpatient Therapy Services

We will review paid claims data for Medicare outpatient therapy services from 2009 and identify questionable billing patterns. We will identify counties with high utilization and compare utilization in these counties to national averages. We will also determine the extent to which billing characteristics in high-utilization counties, including questionable characteristics that may indicate fraud, differed from billing characteristics nationwide..

(OEI; 04-09-00540; expected issue date: FY 2011; work in progress)

Appropriateness of Medicare Payments for Polysomnography

We will review the appropriateness of Medicare payments for sleep studies. Sleep studies are reimbursable for patients who have symptoms consistent with sleep apnea, narcolepsy, impotence, or parasomnia in accordance with the CMS *Medicare Benefit Policy Manual*, Pub. No. 102, ch. 15, § 70. Medicare payments for polysomnography increased from \$62 million in 2001 to \$235 million in 2009, and coverage was also recently expanded. We will also examine the factors contributing to the rise in Medicare payments for sleep studies and assess provider compliance with Federal program requirements.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Payments for Sleep Testing

We will review the appropriateness of Medicare payments for sleep test procedures provided at sleep disorder clinics. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.” CMS’s *Medicare Benefit Policy Manual*, Pub. No. 100-02, ch. 15, § 70, provides CMS’s requirements for coverage of sleep tests under Part B. A preliminary OIG review identified improper payments when certain modifiers are not reported with sleep test procedures. We will examine Medicare payments to physicians and independent diagnostic testing facilities for sleep test procedures to determine whether they were in accordance with Medicare requirements.

(OAS; W-00-10-35521; W-00-11-35521; various reviews; expected issue date: FY 2011; work in progress)

Excessive Payments for Diagnostic Tests

We will review Medicare payments for high-cost diagnostic tests to determine whether they were medically necessary. The Social Security Act, § 1862 (a)(1)(A), provides that Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.” We will determine the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialists for the same treatment.

(OAS; W-00-11-35454; various reviews; expected issue date: FY 2011; new start)

Laboratory Test Unbundling by Clinical Laboratories

We will review the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments. Pursuant to CMS’s *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 16, § 90, to ensure the accuracy of payments, Medicare contractors must group together individual laboratory tests that clinical laboratories can perform at the same time on the same equipment and then consider the price of related profile tests. Payment for individual tests must not exceed the lower of the profile price or the total price of all the individual tests. We will determine whether clinical laboratories have unbundled profile or panel tests by submitting claims for multiple dates of service or by

drawing specimens on sequential days. We will also determine the extent to which the Medicare carriers have controls in place to detect and prevent inappropriate payments for laboratory tests.

(OAS; W-00-11-35222; various reviews; expected issue date: FY 2011; new start)

Medicare Part B Payments for Glycated Hemoglobin A1C Tests

We will review Medicare contractors' procedures for screening the frequency of clinical laboratory claims for glycated hemoglobin A1C tests. CMS's *Medicare National Coverage Determinations Manual*, Pub. 100-03, Ch. 1, pt. 3, § 190.21, states that it is not considered reasonable and necessary to perform a glycated hemoglobin test more often than every 3 months on a controlled diabetic patient unless documentation supports the medical necessity of testing in excess of national coverage determinations guidelines. Preliminary OIG work at two Medicare contractors showed variations in the contractors' procedures for screening the frequency of glycated hemoglobin A1C tests. We will determine the appropriateness of Medicare payments for glycated hemoglobin A1C tests.

(OAS; W-00-11-35455; various reviews; expected issue date: FY 2011; new start)

Trends in Laboratory Utilization

We will review trends in laboratory utilization under the Medicare program. Pursuant to 42 CFR § 410.32(a), Medicare pays only for laboratory tests that are ordered by a physician or qualified nonphysician practitioner who is treating a beneficiary. In 2008, Medicare paid about \$7 billion for clinical laboratory services, which represents a 92 percent increase from 1998. Much of the growth in laboratory spending was the result of increased volume of ordered services. We will examine the types of laboratory tests and the number of laboratory tests ordered. We will also examine how physician specialty, diagnosis, and geographic difference in the practice of medicine affect laboratory test ordering.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Lab Test Payments: Comparison of Medicare with Other Public Payers

We will review the extent to which Medicare payment rates for laboratory tests vary from other public payers. Excessive payment rates for laboratory tests can be costly for the Medicare program. In 2009, Medicare paid nearly \$10 billion for lab tests. We will compare Medicare laboratory payment rates for the 10 most utilized lab tests with those of other public payers, including the Department of Veterans Affairs (VA) and State Medicaid programs.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Geographic Areas With a High Density of Independent Diagnostic Testing Facilities

We will review services and billing patterns in geographic areas with high concentrations of independent diagnostic testing facilities (IDTF). IDTFs are facilities that perform diagnostic procedures and are independent of physicians' offices or hospitals. An IDTF may have a fixed location or be a mobile entity, and the practitioner performing the procedures may be a

nonphysician. IDTFs must meet regulatory performance requirements at 42 CFR § 410.33 to obtain and maintain Medicare billing privileges. A 2006 OIG review found numerous problems with IDTFs, including noncompliance with Medicare standards and potential improper payments of \$71.5 million. We will also examine billing patterns in areas with a high density of IDTFs.

(OEI; 09-09-00380; expected issue date: FY 2011; work in progress)

Independent Diagnostic Testing Facilities' Compliance With Medicare Standards

We will review selected IDTFs enrolled in Medicare to determine the extent to which they comply with selected Medicare standards. IDTFs received payments of about \$860 million in 2009. Federal regulations at 42 CFR § 410.33, require IDTFs to certify on their enrollment applications that they comply with 17 standards. Such standards include requirements that IDTFs comply with all of the Federal and State licensure and regulatory requirements that are applicable to the health and safety of patients, provide complete and accurate information on their enrollment applications, and have on duty technical staff members who hold appropriate credentials to perform tests. We will also identify billing patterns associated with IDTFs that were not compliant with selected Medicare standards.

(OEI; 05-09-00560; expected issue date: FY 2011; work in progress)

Comprehensive Outpatient Rehabilitation Facilities

We will review national Medicare utilization patterns for Comprehensive Outpatient Rehabilitation Facility (CORF) services and identify CORFs in high-utilization areas. Medicare paid about \$61 million for 35,000 beneficiaries who received CORF services in 2009. Previous OIG work identified CORF services that did not meet Medicare reimbursement standards because they were not medically necessary or lacked documentation that they were provided. OIG has also raised concern about potentially inappropriate rental arrangements between physician landlords and CORFs. Federal regulations at 42 CFR § 485.62, require that CORFs maintain locations that provide safe and sufficient space for the scope of all services offered. We will conduct site visits to determine whether CORFs in high-utilization areas meet basic Medicare requirements. We will also identify differences in billing patterns of CORFs that met selected Medicare requirements and those that did not.

(OEI; 05-10-00090; expected issue date: FY 2011; work in progress)

Medicare Providers' Compliance With Assignment Rules

We will review the extent to which providers comply with assignment rules and determine whether and to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare requirements. Pursuant to the Social Security Act, § 1842(h)(1), physicians participating in Medicare agree to accept payment on an "assignment" for all items and services furnished to individuals enrolled in Medicare. CMS defines "assignment" as a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to allow the physician or other supplier to request direct payment from Medicare for covered Part B services, equipment, and supplies by assigning the claim to the

physician or supplier. The physician or other supplier in return agrees to accept the Medicare-allowed amount indicated by the carrier as the full charge for the items or services provided. We will also assess beneficiaries' awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines.
(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Payments for Claims Deemed Not Reasonable and Necessary

We will review Medicare payments for Part B claims in 2009 that providers note as not reasonable and necessary on claim submissions. The CMS *Claims Processing Manual* states that providers may use GA or GZ modifiers on claims they expect Medicare to deny as not reasonable and necessary. A recent OIG study found that Medicare paid for 72 percent of pressure-reducing support surface claims with GA or GZ modifiers, amounting to \$4 million in potentially inappropriate payments. We will determine the extent to which Medicare paid for Part B claims with these modifiers, as well as the types of providers and the types of services associated with these claims. We will also assess the policies and practices that Medicare contractors have in place with regard to these claims.
(OEI; 02-10-00160; expected issue date: FY 2011; work in progress)

Medicare Billings With Modifier GY

We will review the appropriateness of providers' use of modifier GY on claims for services that are not covered by Medicare. CMS's *Medicare Carriers Manual*, Pub. No. 14-3, pt. 3, § 4508.1, states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Pursuant to CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 1, § 60.1.1, providers are not required to give beneficiaries advance notice of charges for services that are excluded from Medicare by statute. As a result, beneficiaries may unknowingly acquire large medical bills for which they are responsible. In FY 2008, Medicare received over 75.1 million claims with a modifier GY totaling approximately \$820 million. We will examine patterns and trends for physicians' and suppliers' use of modifier GY.
(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Payments for Services Ordered or Referred by Excluded Providers

We will review the nature and extent of Medicare payments for services ordered or referred by excluded providers. Pursuant to the Social Security Act, §§ 1128 and 1156, and 42 CFR § 1001.1901, no payment shall be made for any items or services furnished, ordered, or prescribed by an excluded individual or entity. We will examine CMS's oversight mechanisms to identify and prevent improper payments for services based on orders or referrals by excluded providers.
(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Payments for ESRD Beneficiaries Entitled to Medicare Under Special Provisions

We will review claims for end stage renal disease (ESRD) beneficiaries entitled to Medicare coverage only because of special circumstances. Individuals who are medically determined to have ESRD may become eligible for Medicare benefits regardless of age. The Social Security Act, § 226A(b)(2), limits Medicare coverage to the 36th month after the month in which such individual receives a kidney transplant or the 12th month after the month in which such course of dialysis is terminated in the case of an individual who has not received a kidney transplant and no longer requires a regular course of dialysis. Our preliminary analysis identified ESRD-eligible beneficiaries who were still receiving Medicare benefits beyond the 36-month timeframe. We will determine the extent to which beneficiaries who are eligible for Medicare benefits because of special provisions continue to obtain Medicare benefits after their coverage should have ended.

(OAS; W-00-11-35456; various reviews; expected issue date: FY 2011; new start)

Error-Prone Providers: Medicare Part A and Part B

We will review Medicare Part A and Part B claims submitted by error-prone providers. CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 requires providers to submit accurate claims for services provided to Medicare beneficiaries. Previous OIG work illustrated a methodology for identifying error-prone providers using CMS's Comprehensive Error Rate Testing (CERT) Program data. Using this methodology, we identified providers that consistently submitted claims found to be in error in a 4-year period. We will select the top error-prone providers based on expected dollar error amounts and match selected providers against the National Claims History file to determine the total dollar amount of claims paid. We will then conduct a medical review on a sample of claims to determine their validity, project our results to each provider's population of claims, and request refunds on projected overpayments.

(OAS; W-00-11-40044; various reviews; expected issue date: FY 2011; new start)

Comprehensive Error Rate Testing Program: FY 2010 Error Rate Oversight

The Improper Payments Information Act of 2002 (IPIA) requires the head of a Federal agency with any program or activity that may be susceptible to significant improper payments to report to Congress the agency's estimate of improper payments. For any program or activity with estimated improper payments exceeding \$10 million, the agency must report to Congress the actions that the agency is taking to reduce those payments. OMB identified CMS as an agency with high-profile programs that are susceptible to significant improper payments. In November 2003, CMS assumed responsibility for estimating and reporting improper Medicare fee-for-service payments and national error rates. The CERT Program, implemented in CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 12, was established by CMS to meet the requirements of the IPIA and to monitor the accuracy with which Medicare claims are billed and paid. Effective August 1, 2008, the CERT program also samples inpatient records replacing the Hospital Payment Monitoring Program (HPMP). Through CERT, national, contractor-specific, , and service-type error rates are computed. The CERT program's national estimated

improper payments for FY 2009 were \$24.1 billion (7.8 percent error rate). We will review certain aspects of the CERT Program to evaluate CMS's efforts to ensure the accuracy of the FY 2010 error rate and to reduce improper payments.

(OAS; W-00-11-40048; various reviews; expected issue date: FY 2011; new start)

Medicare Services Billed With Dates of Service After Beneficiaries' Dates of Death

We will review Medicare claims with dates of service after beneficiaries' dates of death to assess CMS's controls to preclude or identify and recover improper FFS payments. Pursuant to 42 CFR § 407.27(a), entitlement to supplementary medical insurance (Part B) ends on the last day of the month in which the beneficiary dies. To monitor Medicare eligibility effectively, CMS uses several computer database systems that interface with death information on the Social Security Administration's and the Railroad Retirement Board's systems. CMS's *Medicare Financial Management Manual*, Pub. No. 100-06, ch. 3, § 10, defines an "overpayment" as a Medicare payment that a provider received in excess of amounts due and payable under the statute and regulations. The Federal Claims Collection Act of 1966 (FCCA), United States Code (U.S.C.), Title 31 § 3711, as implemented by Federal regulations at 31 CFR § 901.1, requires the recovery of overpayments.

(OAS: W-00-09-35435; W-00-10-35435; various reviews; expected issue date: FY 2011; work in progress)

Medical Equipment and Supplies

Medicare Payments for Various Categories of Durable Medical Equipment

We will review the appropriateness of Medicare Part B payments to DME suppliers of power mobility devices (e.g., scooters), hospital beds and accessories, oxygen concentrators, and enteral/parenteral nutrition. Pursuant to the Social Security Act, §§ 1862(a)(1)(A) and 1833(e), Medicare will not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." Prior OIG reviews have identified issues such as Medicare payments for DME that was not ordered by physicians, not delivered to the beneficiaries, or not needed by beneficiaries. We will identify DME suppliers in selected geographic areas with high-volume claims and reimbursement to determine whether payments were in accordance with Medicare requirements.

(OAS; W-00-10-35223; W-00-11-35223; various reviews; expected issue date: FY 2011; work in progress)

Frequency of Replacement Supplies for Durable Medical Equipment

We will review the compliance of suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) with Medicare requirements for frequently replaced DME supplies. The Social Security Act, § 1862(a)(1)(A), requires that Medicare not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or

injury or to improve the functioning of a malformed body member.” CMS’s *Medicare Program Integrity Manual*, Pub. 100-08, ch. 5, §§ 2.3 and 5.9, states that for DME supplies and accessories used on a periodic basis, the order or Certificate of Medical Necessity must specify the type of supplies needed and the frequency with which they must be replaced, used, or consumed. CMS’s *Medicare Claims Processing Manual*, Pub. 100-04, ch. 20, § 200, states that a beneficiary or a beneficiary’s caregiver must specifically request refills of repetitive services and/or supplies before a supplier dispenses them. It further states that a supplier may not initiate a refill of an order and that a supplier must not automatically dispense a quantity of supplies on a predetermined regular basis. Preliminary OIG work showed that suppliers automatically shipped continuous positive airway pressure system and respiratory-assist device supplies when no physician order for refills was in effect. We will select a sample of claims for frequently replaced supplies to determine whether payments to DME suppliers met Medicare requirements.

(OAS; W-00-11-35240; various reviews; expected issue date: FY 2011; new start)

Medicare Payments to Durable Medical Equipment Suppliers for Power Wheelchairs

We will review documentation for payments to DME suppliers for standard and complex rehabilitation power wheelchairs to determine whether the claims were medically necessary. Pursuant to the Social Security Act, § 1832(a)(1), and regulations at 42 CFR §§ 410.10(h) and 410.38, beneficiaries are eligible to receive power wheelchairs under Medicare Part B, which covers DME. The Social Security Act, § 1862(a)(1), says that items provided under Part B must be “reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.” We will also determine whether suppliers had documentation from the beneficiaries’ medical records, as required, that supported the medical necessity of the power wheelchairs and whether this was consistent with documentation from the physicians who ordered the power wheelchairs.

(OEI; 04-09-00260; expected issue date: FY 2011; work in progress)

Medicare Payments for Durable Medical Equipment Claims With Modifiers

We will review the appropriateness of Medicare Part B payments to DME suppliers that submitted claims with modifiers. The Social Security Act, § 1833(e), precludes payments to any service provider unless the provider has furnished the information necessary to determine the amounts due such provider. For certain items to be covered under the Medicare program, DME suppliers must use modifiers to indicate that they have the appropriate documentation on file; the suppliers are required to provide, upon request, the documentation to support their claims for payment. Reviews of suppliers conducted by several of CMS’s DME MACs found that suppliers had little or no documentation to support their claims, suggesting that many of the claims submitted may have been invalid and should not have been paid by Medicare. We will determine whether payments to DME suppliers met Medicare requirements.

(OAS; W-00-09-35305; W-00-10-35305; W-00-11-35305; various reviews; expected issue date: FY 2011; work in progress)

Competitive Bidding Process for Medical Equipment and Supplies

We will review the process CMS used to conduct competitive bidding and subsequent pricing determinations for certain DMEPOS items and services in selected competitive bidding areas under rounds 1 and 2 of the competitive bidding program. Section 154(a)(1)(E) of the MIPPA requires OIG to conduct postaward audits to assess the process used by CMS for competitive bidding and subsequent pricing determinations under rounds 1 and 2 of the competitive bidding program.

(OAS; W-00-11-35241; various reviews; expected issued date: FY 2011; new start)

Competitive Bidding Program: Supplier Influence on Physician Prescribing

We will review DME claims to determine the extent to which suppliers participating in the competitive bidding program are soliciting physicians to prescribe certain brands or modes of delivery of covered items that are more profitable to suppliers. Pursuant to the Social Security Act, § 1847, CMS is required to establish a competitive bidding process for the purchase of selected DME items, which Congress subsequently delayed until 2011. Section 1847 requires that OIG conduct reviews (including this evaluation) examining the competitive bidding process. We will also examine billing patterns to identify changes resulting from competitive bidding.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Pricing for Parenteral Nutrition

We will review Medicare's fee schedule for parenteral nutrition, compared with fees paid by other sources of reimbursement. Parenteral nutrition is the practice of feeding a person intravenously to replace the function of a permanently inoperative or malfunctioning internal body organ and is covered under the prosthetic device benefit of the Social Security Act, § 1861(s)(8). In 2009, Medicare paid more than \$137 million for parenteral nutrition supplies. Previous OIG work found that Medicare allowances for major parenteral nutrition codes averaged 45 percent higher than Medicaid prices, 78 percent higher than prices available to Medicare risk-contract health maintenance organizations, and 11 times higher than some manufacturers' contract prices. We will also identify reimbursement amounts paid by public and private payers for parenteral nutrition services.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Part B Payments for Home Blood Glucose Testing Supplies

We will review Medicare Part B payments for home blood glucose test strips and lancet supplies. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." The local coverage determinations (LCD) issued by the four DME MACs require that the physician's order for each item billed to Medicare include certain elements and be retained by the supplier to support billing for those services. Further, the LCDs require that the supplier add a modifier to identify when a patient is treated with insulin or not treated with insulin. The amount of supplies

allowable for Medicare reimbursement differs depending on the applicable modifier. We will determine the appropriateness of Medicare Part B payments to DME suppliers for home blood glucose test strips and lancet supplies.

(OAS; W-00-08-35407; W-00-10-35407; W-00-11-35407; various reviews; expected issue date: FY 2011; work in progress)

Medicare Market Shares of Mail-Order Diabetic Testing Strips

We will determine the brands and models of diabetic testing strips reimbursed by Medicare. The Social Security Act, § 1847(b)(10)(B), requires OIG to complete a study of diabetic testing strip products and submit it to the Secretary before January 1, 2011. CMS may use the results of this study in future rounds of competitive bidding for mail-order diabetic testing strips to ensure that suppliers that submit winning bids are able to provide beneficiaries' preferred types of testing strips. We will also determine the market shares of diabetic testing strips that Medicare beneficiaries receive by mail order.

(OEI; 04-10-00130; expected issue date: FY 2011; work in progress)

Medicare Enrollment and Monitoring for Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

We will review Medicare contractors' processes for enrolling and monitoring suppliers of DMEPOS. Pursuant to CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 10, § 1.3, Medicare contractors must conduct prescreening, verification, validation, and final processing of Medicare provider enrollment applications. A recent OIG study found that suppliers omitted or provided inaccurate information on enrollment applications, which resulted in improper enrollment. We will assess Medicare contractors' use of enrollment-screening mechanisms and post-enrollment monitoring activities to identify applicants that pose fraud risks to Medicare and the extent to which applicants omitted ownership information on enrollment applications.

(OEI; 06-09-00230; expected issue date: FY 2011; work in progress)

Medicare Qualifications of Orthotists and Prosthetists

We will review the extent to which Medicare claims for orthotics and prosthetics were paid to unqualified practitioners in 2009. We will also assess whether CMS provided guidance to State licensing boards and industry on how to define a "qualified practitioner" of orthotics and prosthetics. Pursuant to the Social Security Act, § 1834(h)(1)(F), "Special Payment Rules for Certain Prosthetics and Custom-Fabricated Orthotics," no payment will be made for such items unless provided by a qualified practitioner as defined in the statute. Previous OIG work found that miscoded orthotics represented \$33 million in inappropriate Medicare payments in 1998 because the device did not meet the specifications billed, the device was not custom-fabricated, or the part billed was already included in the base code for a larger device. OIG concluded that the qualifications of orthotic suppliers varied, with noncertified suppliers most likely to provide inappropriate devices and services. We will review the credentials of a sample of providers submitting orthotic and prosthetic claims and determine the extent to

which CMS provides oversight of credentialing of orthotists and prosthetists.
(OEI; 07-10-00410; expected issue date: FY 2011; work in progress)

Medicare Part B Payments for Lower-Limb Prostheses in 2009

We will review Medicare payments for lower-limb prostheses in 2009. In 2009, Medicare paid about \$655 million for lower-limb prostheses, which represented 82 percent of Medicare Part B payments for all prostheses. Over the last 5 years, payments for lower-limb prostheses increased by 27 percent. We will also assess the policies and practices that Medicare contractors have in place for lower-limb prosthetic claims to prevent fraud, waste, and abuse.

(OEI; 02-10-00170; expected issue date: FY 2011; work in progress)

Part B Payments for Prescription Drugs

Comparing Average Sales Prices to Average Manufacturer Prices

We will periodically review Medicare Part B drug prices by comparing average sales prices (ASP) to average manufacturer prices (AMP). In 2005, Medicare began paying for most Part B drugs using a new methodology based on the ASP. The Social Security Act, § 1847A(d), requires that OIG compare ASPs to AMPs for Part B drugs and notify the Secretary, at such times as the Secretary may specify, if the ASP for a selected drug exceeds the AMP by a threshold of 5 percent. We will compare ASPs to AMPs for Part B drugs and identify drug prices that exceed the threshold.

(OEI; 00-00-00000; various studies; expected issue date: FY 2011; new start)

Comparison of Average Sales Prices to Widely Available Market Prices for Selected Drugs

We will periodically review widely available market prices (WAMP) for selected prescription drugs covered by Part B and compare them to ASPs for those drugs. In 2005, Medicare began paying for most Part B drugs using a new methodology based on the ASP. The Social Security Act, § 1847A(d), requires OIG to conduct studies that compare ASPs to WAMPs for Part B-covered drugs. If OIG finds that the ASP of a drug exceeds the WAMP by a certain threshold (now 5 percent), CMS is required to base payment for the drug on the lesser of the WAMP or 103 percent of the AMP. This study will estimate the WAMPs of prescription drugs that have been identified in earlier OIG reports and compare the WAMPs to the drugs' ASPs.

(OEI; 03-10-00280; expected issue date: FY 2011; work in progress)

Fluctuation of Average Sales Price for Medicare Part B Drugs

We will review trends and variations in quarterly ASPs from the implementation of the payment methodology in 2005 to the present. Section 303(c) of the MMA established the ASP as the basis for reimbursement for Part B-covered drugs. We will determine the degree of fluctuation in ASPs from quarter to quarter and examine the potential monetary impact of ASP

fluctuation on Part B payments for drugs. We will also determine how these fluctuations compare to price-change indexes developed by the Bureau of Labor Statistics (BLS).
(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Medicare Payments for Part B Drugs

We will review services associated with Medicare claims for Part B drugs. CMS's *Medicare Benefits Policy Manual*, Pub. No. 100-02, ch. 15, § 50, says that Medicare Part B provides limited benefits for outpatient drugs. Medicare Part B covers drugs that are furnished "incident to" a physician's service provided that the drugs are not usually self-administered by the patients who take them. (The term "usually" here means more than 50 percent of the time for all Medicare beneficiaries who use the drug.) We will determine whether Medicare payments for the Part B drugs, where associated with a physician service, were in accordance with Medicare requirements.

(OAS; W-00-11-35242; various reviews; expected issue date: FY 2011; new start)

Billing for Immunosuppressive Drugs

We will review Medicare Part B immunosuppressive drug claims to determine whether they were billed according to their Food and Drug Administration (FDA)-approved labels. Pursuant to the Social Security Act, § 1832(a)(2), and CMS's *Medicare Benefits Policy Manual*, Pub. No. 100-02, ch. 15, § 50, Medicare Part B covers drugs that are not usually self-administered and are furnished incident to physicians' services, such as immunosuppressive drugs. The manual also states in section 50 that use of such drugs must be safe and effective and otherwise reasonable and necessary and that "drugs or biologicals approved for marketing by the FDA are considered safe and effective for purposes of this requirement when used for indications specified on the labeling." Several FDA-approved labels for immunosuppressive drugs state that the drugs should not be used in combination with other immunosuppressive drugs. We will also determine whether Medicare paid for immunosuppressive drugs that should not have been used in combination with other immunosuppressive drugs.

(OAS; W-00-11-35434; various reviews; expected issue date: FY 2011; new start)

Payments for Off-Label Anticancer Pharmaceuticals and Biologicals

We will review Medicare payments for drugs and biologicals used on an off-label basis in anticancer chemotherapeutic regimens. The Social Security Act, § 1861(t)(2), provides coverage of FDA-approved drugs used for off-label indications in anticancer chemotherapeutic regimens where such uses are supported in authoritative compendia identified by the Secretary of Health & Human Services. Federal regulations at 42 CFR § 414.930(b) established a process for identifying authoritative sources of information. The DrugDex, a drug compendium, defines drugs in the class we will review as being medically accepted even though the given tests or treatments are indicated in only some cases and even where evidence and/or expert opinions argue against efficacy. In CY 2007, Medicare payments for anticancer drugs totaled about \$2.7 billion. We will determine whether patients with particular indications were prescribed anticancer drugs approved by FDA for such indications before resorting to anticancer drugs not

approved for those indications and, if so, whether there were improvements in the patients' medical conditions before the use of off-label drugs. If the beneficiaries' medical conditions improved before the use of off-label drugs, we will determine how much Medicare could have saved had anticancer drugs continued to be used within indicated usage.

(OAS; W-00-11-35504; various reviews; expected issue date: FY 2011; new start)

Acquisition Costs and Payments for Lucentis and Avastin Used in Treating Wet Age-Related Macular Degeneration

We will review how physicians' acquisition costs compare to Medicare Part B payments for two drugs used to treat wet age-related macular degeneration (AMD), the leading cause of blindness in the elderly. Lucentis is a drug specifically approved by FDA to treat wet AMD, and Avastin is approved to treat cancer. However, eye doctors have been using smaller doses of Avastin off-label as a treatment for wet AMD. CMS recently enacted and then reversed its decision to pay a lower amount for Avastin when used to treat wet AMD after physicians claimed that the new payments were too low and would require them to prescribe the higher-priced Lucentis. Medicare may subsequently be paying substantially more than the acquisition cost for Avastin when it is used to treat wet AMD. The smaller Avastin dose used to treat wet AMD must be prepared in a sterile environment through a process known as compounding. We will also examine the additional compounding cost for Avastin.

(OEI; 03-10-00360; expected issue date: FY 2011; work in progress)

Usage Patterns and Payments for Avastin and Lucentis in Treating Wet Age-Related Macular Degeneration

We will review National Claims History data to identify nationwide usage patterns and payments for two drugs used to treat wet AMD. Pursuant to SSA § 1861(t)(2), CMS's *Medicare Benefits Policy Manual*, Pub No. 100-02, ch. 15, § 50.4.2, says that Medicare Part B may cover drugs that are used for indications other than those listed on the official label if the Medicare contractor determines the use to be medically accepted. Avastin, approved by FDA as a colorectal cancer drug, is also used off-label to treat wet AMD. The FDA has approved the use of Lucentis for AMD. Both drugs are physician administered and are covered under Medicare Part B. MACs have issued LCDs allowing for reimbursement for Avastin use off-label to treat wet AMD. Initial results of the Comparison of Age-Related Macular Degeneration Treatments Trials (CATT) study that compares the safety and efficacy of the two drugs from the National Eye Institute of the National Institutes of Health (NIH) are expected in late 2010 or early 2011. We will determine whether a significant savings can be recognized if either Avastin or Lucentis is used more by ophthalmologists.

(OAS; W-00-10-35535; various reviews; expected issue date: FY 2011; work in progress)

Medicare Part A and Part B Contractor Operations

Preaward Reviews of Contract Proposals

We will review the cost proposals of various bidders for Medicare contracts based on criteria in Office of Management and Budget (OMB) Circular A-122, *Cost Principles for Non-Profit Organizations*. The reports produced by these reviews assist CMS in negotiating favorable and cost-beneficial contract awards.

(OAS; W-00-10-35002; W-00-11-35002; various reviews; expected issue date: FY 2011; work in progress)

Contractors' Administrative Costs

We will review administrative costs claimed by various contractors for their Medicare activities, focusing on costs claimed by terminated contractors. We will determine whether the costs claimed were reasonable, allocable, and allowable under Appendix B of the Medicare contract with CMS, as well as the Federal Acquisition Regulation (FAR) at 48 CFR pt. 31. We will coordinate the selection of contractors with CMS.

(OAS; W-00-09-35005; W-00-10-35005; W-00-11-35005; various reviews; expected issue date: FY 2011; work in progress)

Medicare Summary Notice

We will review beneficiaries' use and understanding of Medicare Summary Notices (MSN). MSNs advise beneficiaries of claims paid for health care services and supplies. CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 21, § 10, contains contractor requirements for issuing MSNs. On its Web site and in the *Medicare & You* publication, CMS emphasizes the importance of checks by beneficiaries of their MSNs for any services or supplies that they do not recognize. We will review beneficiaries' experiences and understanding of MSNs.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Handling of Hotline Referrals

We will review CMS's handling of complaints referred by OIG from callers to the hotline. OIG operates 1-800-HHS-TIPS to receive calls alleging fraud, waste, or mismanagement in HHS programs, such as Medicare. The availability of the hotline is widely publicized on the Internet and in various publications, including CMS's *Medicare & You* booklet, which is distributed annually to Medicare beneficiaries. In 2009, the hotline referred about 2,580 complaints to CMS for assessment and appropriate action. We will review CMS's handling of these referrals, including its research related to the issues of the complaints, corrective actions taken, and communications with the complainants.

(OEI; 07-09-00020; expected issue date: FY 2011; work in progress)

Quality Improvement Organization's Hospital Quality Improvement Projects

We will review the effectiveness of the quality improvement projects QIOs conducted with hospitals. Among other responsibilities specified in CMS's *Quality Improvement Organization*

Manual, Pub. 100-10, Ch. 1, § 1020, QIOs must work with hospitals on projects designed to improve performance on specific quality measures. In the QIOs' most recently completed 3-year contract, the measures focused on acute myocardial infarction, heart failure, pneumonia, and surgical care measures. QIOs are responsible for identifying and recruiting participant hospitals, then working with them on process improvements. We will also determine whether hospitals sustained improvements after their projects concluded.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

First Level of the Medicare Appeals Process

We will review the timeliness of Medicare contractors in making determinations on requests for reconsideration at the first level of Medicare appeals. Pursuant to the Social Security Act, § 1869(a)(3)(C)(ii), Medicare contractors have 60 days to conclude a redetermination regarding a denied claim. We will review the processes that Medicare contractors use to conduct first-level Medicare appeals.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Administrative Law Judge Decisions

We will review the characteristics of cases brought before Medicare administrative law judges (ALJs) in 2009 and describe how Medicare ALJs conduct hearings and decide cases. We will also describe the extent to which CMS participates in ALJ hearings. There are four levels of the Medicare administrative appeals process within HHS. The third level of appeals consists of ALJ hearings and is governed by the Social Security Act, § 1869(d). The process is administered by the HHS Office of Medicare Hearings and Appeals (OMHA). We will review case files of a sample of recent ALJ hearings as well as interview relevant OMHA and CMS officials.

(OEI; 02-10-00340; expected issue date: FY 2011; work in progress)

Accuracy of the National Provider Enumeration and Medicare Provider Enrollment Data

We will review the extent to which national provider identifier (NPI) enumeration data and Medicare Provider Enrollment, Chain and Ownership System (PECOS) data are complete, consistent, and accurate. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required the Secretary of HHS to establish a standard unique health identifier for each health care provider, health care organization, and health plan for use in the health care system. The Secretary established the NPI to address this requirement. Separately, 42 CFR § 424.505 requires providers to enroll to receive payment from Medicare, and PECOS is the system CMS uses to complete the enrollments online. We will assess CMS's processes for ensuring the completeness, consistency, and accuracy of NPI and PECOS data.

(OEI; 07-09-00440; expected issue date: FY 2011; work in progress)

Medicare Secondary Payer Recovery Contractor: Early Implementation

We will review the effectiveness of the Medicare Secondary Payer (MSP) recovery process. Pursuant to the Social Security Act, § 1862(b), the MSP recovery process seeks reimbursement of

Medicare payments for which another insurer was primary to Medicare. In October 2006, CMS consolidated most recovery functions under a single MSP Recovery Contractor (MSPRC) to increase recoveries, enhance customer service, and improve the efficiency and consistency of the process. Since October 2006, the contractor has been responsible for most MSP recovery efforts when Medicare has paid a claim in error, or made a conditional payment for which another payer is ultimately deemed responsible. We will determine whether the MSPRC has increased recoveries, decreased administrative costs, and improved the efficiency of the recovery process. (OEI; 00-00-00000; expected issue date: FY 2012; new start)

Medicare Administrative Contractors: Quality Assurance Surveillance Plan Performance Evaluation

We will review Quality Assurance Surveillance Plan (QASP) performance evaluation reports of MACs to determine whether the reports address the results of activities performed by the MACs. Section 911 of the MMA requires that the Secretary administer Medicare Part A and Part B through contracts with MACs. The section also requires the Secretary to develop specific performance requirements and standards for measuring the extent to which a MAC has met such requirements. To assist in its oversight, CMS developed the QASP review process for use in monitoring and evaluating MACs performance. Each fiscal year, CMS prepares a QASP report of contractor performance that summarizes the results of oversight activities that occurred during the year. We will also determine how CMS addressed any deficiencies identified by the QASP reports.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Zone Program Integrity Contractors' Identification of Potential Fraud and Abuse

We will review the extent to which Zone Program Integrity Contractors (ZPIC) identified and investigated potential fraud and abuse incidents and whether these incidents were identified through proactive or external sources. Under section 911 of the MMA, CMS created ZPICs to replace program safeguard contractors (PSCs) and consolidate all program integrity functions under one type of contractor. We will determine whether ZPICs addressed potential fraud and abuse incidents, responded to requests from law enforcement, and encountered any issues or barriers in performing their contractual responsibilities.

(OEI; 03-09-00520; expected issue date: FY 2011; work in progress)

Conflicts of Interest in the Zone Program Integrity Contracting Process

We will review CMS's process for overseeing contractors' organizational conflicts of interest during the ZPIC award process and throughout the period of performance. The FAR (48 CFR subpart 9.5), along with the Health and Human Services Acquisition Regulation (HHSAR) and other authorities, prescribe the responsibilities, general rules, and procedures to identify, evaluate, and resolve organizational conflicts of interest. We will determine the extent to which ZPICs disclosed conflicts of interest and examine how they resolved the identified conflicts of interest, as well as determine how CMS addresses personal conflicts of interest among members

of the Technical Evaluation Panel used during the awards process.
(OEI; 03-10-00300; expected issue date: FY 2011; work in progress)

Vulnerabilities Identified by Medicare Benefit Integrity Contractors

We will review how CMS addresses vulnerabilities identified by PSCs, ZPICs, and Medicare Drug Integrity Contractors (MEDIC). As outlined in CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, PSCs and ZPICs are responsible for preventing, detecting, and deterring fraud and abuse. Chapter 4, § 4.31, of the manual states that PSCs and ZPICs are required to report vulnerabilities to CMS on monthly cost reports and on quarterly vulnerability reports. Section 8.2.12 of the MEDIC Statement of Work (SOW) requires MEDICs to submit a quarterly vulnerability report. The Government Accountability Office (GAO) recently reported that CMS did not adequately address vulnerabilities found by its recovery audit contractors. We will determine the numbers and types of actions CMS took to address vulnerabilities identified by PSCs, ZPICs, and MEDICs.

(OEI; 03-10-00500; expected issue date: FY 2011; work in progress)

Identification and Recoupment of Improper Payments by Recovery Audit Contractors

We will review the performance of the Recovery Audit Contractor (RAC) program. The RACs conduct postpayment reviews to identify overpayments and underpayments and attempt to recoup any overpayments they find. Following a 3-year demonstration project, the Tax Relief and Health Care Act of 2006 (TRHCA), § 302, mandated nationwide implementation of a permanent RAC program for Medicare Parts A and B. Section 6411 of the Affordable Care Act expanded the RAC program, giving it additional responsibilities to address improper payments in Medicaid, Medicare Part D (Prescription Drug Benefit), and Medicare Part C (Medicare Advantage). Previous OIG work found problems with RACs' process for identifying and reporting potential fraud during the RAC demonstration project. We will also review CMS's oversight of the RAC program.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Providers and Suppliers with Currently Not Collectible Debt

We will review the number and dollar value of Medicare Parts A and B overpayments that CMS deemed as currently not collectible (CNC) and review CMS's actions to reduce and recover CNC debt. CMS defines a CNC debt as a Medicare overpayment that remains uncollected 210 days after the provider or supplier is notified of the debt and for which recovery attempts by CMS contractors have failed. In 2006, the amount of DMEPOS supplier debt deemed CNC was \$402 million. A recent OIG report found that overpayments referred for collection by PSCs in 2007 did not result in substantial recoveries to the Medicare program. Uncollected overpayments could represent a significant program vulnerability. We will also determine whether CNC debtors are closely associated with other businesses that continue to receive Medicare payment.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Variation in Coverage of Services and Medicare Expenditures Due to Local Coverage Determinations

We will review variation in Medicare spending and coverage of services due to LCDs and the evidence Medicare contractors use to develop LCDs. Pursuant to section 521 of the BIPA and the Social Security Act, § 1862(a)(1)(A), a contractor may establish an LCD to enforce its decision about whether a particular item or service is considered reasonable and necessary and is therefore covered under Medicare. These coverage decisions are not national, meaning Medicare could pay for a service for a beneficiary in one location, but deny payment for that service to a beneficiary elsewhere. Over 2,800 LCDs are in effect, but it is not possible to readily calculate the number of claims and the amount of Medicare spending associated with LCDs because claims do not indicate whether an LCD is involved. We will also assess CMS's monitoring and oversight of LCDs.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Performance of the National Supplier Clearinghouse

We will review performance evaluation reports submitted to CMS by the National Supplier Clearinghouse (NSC) to determine whether the NSC performs all contractually required activities and to assess the results of those activities. DMEPOS suppliers are required to comply with the conditions of payment in regulations at 42 CFR pt. 424, subpart P, and 42 CFR § 424.57, which include, among other things, requirements relating to provider enrollment. CMS, through its contract with the NSC, verifies DMEPOS suppliers' initial and continuing compliance with these standards. OIG work in 2007 and 2008 found that fraudulent suppliers continue to enroll and participate in the Medicare program. We will also assess CMS's oversight of the NSC.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Provider Education and Training: Medicare-Affiliated Contractors' Progressive Correction Action

We will review the progressive corrective action (PCA) provider education and training programs conducted by selected Medicare-affiliated contractors to determine whether such programs have reduced billing and payment error rates and aberrant provider behavior. PCA is a medical review tool used by Medicare contractors. In FY 2000, CMS included PCA in its *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 3, as a strategy for conducting medical reviews and provider education and training. Section 921(d) of the MMA directs the Secretary to coordinate educational activities provided through Medicare contractors to maximize the effectiveness of Federal education efforts for providers and oversee contractors' education and training programs. We will also assess CMS's processes for overseeing the education and training programs of selected affiliated contractors.

(OEI; 00-00-00000; expected issue date: FY 2012; new start)

Pension Segmentation

We will review whether Medicare contractors have fully implemented contract clauses requiring them to determine and separately account for the assets and liabilities of the Medicare segments of their pension plans. We will also assess Medicare's share of future pension costs on a segmented basis. Applicable requirements are found in the FAR at 48 CFR § 31.205; Cost Accounting Standards (CAS) 412 and 413; and the Medicare contract, Appendix B, section XVI. (OAS; W-00-10-35094; W-00-11-35094; various reviews; expected issue date: FY 2011; work in progress)

Pension Costs Claimed

We will review whether Medicare contractors have calculated pension costs claimed for reimbursement in accordance with their Medicare contracts and CAS. We will also determine whether the costs claimed were allocable and allowable under the Medicare contracts pursuant to the FAR at 48 CFR § 31.205; CAS 412 and 413; and the Medicare contract, Appendix B, section XVI. (OAS; W-00-10-35067; W-00-11-3-35067; various reviews; expected issue date: FY 2011; work in progress)

Unfunded Pension Costs

We will review whether Medicare contractors identified and eliminated unallowable costs when computing pension costs charged to the Medicare program. We will also determine whether pension costs that would have been tax deductible had they been funded were properly reassigned to future periods to ensure that only allowable pension costs were claimed for reimbursement. Applicable requirements are found in the FAR at 48 CFR § 31.205; CAS 412 and 413; and the Medicare contract, Appendix B, section XVI. (OAS; W-00-10-35148; W-00-11-35148; various reviews; expected issue date: FY 2011; work in progress)

Pension Segment Closing

We will review Medicare carriers and FIs whose Medicare contracts have been terminated, resulting in the closing of the Medicare segments of their pension plans. We will determine the amount of any excess pension assets related to each Medicare segment as of the segment closing date. Requirements of the FAR at 48 CFR § 31.205; CAS 412 and 413; and the Medicare contract, Appendix B, section XVI, provide that pension gains that occur when a Medicare segment closes be credited to the Medicare program. (OAS; W-00-10-35067; W-00-11-35067; various reviews; expected issue date: FY 2011; work in progress)

Postretirement Benefits and Supplemental Employee Retirement Plan Costs

We will review the postretirement health benefit costs and the supplemental employee retirement plans of FIs and carriers. Our reviews will determine the allowability, allocability,

and reasonableness of the benefits and plans, as well as the costs charged to Medicare contracts in accordance with the FAR at 48 CFR §§ 31.201 through 31.205.

(OAS; W-00-10-35095; W-00-11-35095; various reviews; expected issue date: FY 2011; work in progress)