Part I
Medicare Part A and Part B

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Medicare Part A helps cover certain inpatient services in hospitals and skilled nursing facilities (SNF) and some home health services. Medicare Part B helps cover designated practitioners' services; outpatient care; and certain other medical services, equipment, supplies, and drugs that Part A does not cover. Historically, the Centers for Medicare & Medicaid Services (CMS) has contracted with fiscal intermediaries (FI) and carriers to conduct Medicare's claims administration functions. Pursuant to Medicare's contracting reform initiative, FIs and carriers are being replaced by Medicare Administrative Contractors (MAC).

- Fiscal intermediaries have processed claims for Part A and Part B submitted by or on behalf of certain facility-based providers, including hospitals and skilled nursing facilities.

- Carriers have processed claims for Part B submitted by designated practitioners and other suppliers, such as physicians, laboratories, and retail pharmacies. The Centers for Medicare & Medicaid Services (CMS) also engages contractors that perform specific fee-for-service (FFS) business functions.

- MACs process both Part A and Part B claims. CMS is implementing the Medicare contracting reform initiative. The reform plan includes specialty MACs that service suppliers of durable medical equipment. (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 911).

Descriptions of the Office of Inspector General's (OIG) work in progress and planned reviews of Medicare Part A and Part B payments and services for fiscal year (FY) 2013 follow.

Hospitals

Acronyms and Abbreviations for Selected Terms Used in This Section:

CAH—critical access hospital
CoP—conditions of participation (in Medicare)
DGME—direct graduate medical education (costs)
DRG—diagnosis related group
MAC—Medicare Administrative Contractor
MedPAC—Medicare Payment Advisory Commission
IPPS—inpatient prospective payment system
PPS—prospective payment system

Hospitals—Inpatient Billing for Medicare Beneficiaries (New)

We will describe how hospital billing for inpatient stays changed from FY 2008 to FY 2012. We will also describe how billing for inpatient stays in FY 2012 varied among different types of hospitals and how hospitals ensure compliance with Medicare requirements for inpatient billing. In 2010, Medicare paid hospitals $100 billion for inpatient stays. Most hospitals are paid under the inpatient prospective

payment system (IPPS), which CMS changed substantially in FY 2008. Under the IPPS, each inpatient stay is classified into one of 747 Medicare severity diagnosis related groups (MS-DRG) based on the beneficiary's diagnoses and the procedures the hospital performed, as well as other factors. Medicare pays hospitals a different amount for each MS-DRG. *(OEI; 02-10-00100; expected issue date: FY 2013; work in progress)*

Hospitals—Diagnosis Related Group Window (New)

We will analyze claims data to determine how much CMS could save if it bundled outpatient services delivered up to 14 days prior to an inpatient hospital admission into the diagnosis related group (DRG) payment. Medicare currently bundles all outpatient services delivered 3 days prior to an inpatient hospital admission. (Social Security Act, § 1886(a)(4).) Medicare does not pay separately for such preadmission services when they are delivered in a setting owned or operated by the admitting hospital. This policy is commonly known as the "DRG window." Prior OIG work identified improper payments in the DRG window. OIG work has also concluded that CMS could realize significant savings if the DRG window was expanded from 3 days to 14 days. *(OEI; 05-12-00480; expected issue date: FY 2013; work in progress)*

Hospitals—Same-Day Readmissions

We will review Medicare claims to determine trends in the number of same-day hospital readmission cases. On the basis of prior OIG work, CMS implemented an edit (a special system control) in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day. 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 DRG payment and should combine the original and subsequent stays into a single claim. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 3, § 40.2.5.) Providers are permitted to override the edit in certain situations. We will test the effectiveness of the edit. This work may also be helpful to CMS in implementing provisions of the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act). *(OAS; W-00-13-35439; various reviews; expected issue date: FY 2013;* new start; *Affordable Care Act.)*

Hospitals—Non-Hospital-Owned Physician Practices Using Provider-Based Status (New)

We will determine the impact of non-hospital-owned physician practices billing Medicare as provider-based physician practices. We will also determine the extent to which practices using the provider-based status met CMS billing requirements. Provider-based status allows a subordinate facility to bill as part of the main provider. Provider-based status can result in additional Medicare payments for services furnished at provider-based facilities and may also increase beneficiaries' coinsurance liabilities. In 2011, the Medicare Payment Advisory Commission (MedPAC) expressed concerns about the financial incentives presented by provider-based status and stated that Medicare should seek to pay similar amounts for similar services. *(OEI; 04-12-00380; 04-12-00381; expected issue date: FY 2013; work in progress)*

Hospitals—Compliance With Medicare's Transfer Policy (New)

We will review Medicare payments made to hospitals for beneficiary discharges that should have been coded as transfers. We will determine whether such claims were appropriately processed and paid. We will also review the effectiveness of the MAC's claims processing edits used to identify claims subject to the transfer policy. Pursuant to Federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. (42 CFR § 412.4 (e).) In contrast, a hospital that transfers a beneficiary to another facility is paid a graduated per diem rate, not to exceed the full DRG payment that would have been made if the beneficiary had been discharged without being transferred. (42 CFR§ 412.4(f).) *(OAS; W-00-12-35102; various reviews; expected issue date: FY 2013; work in progress)*

Hospitals—Payments for Discharges to Swing Beds in Other Hospitals (New)

We will review Medicare payments made to hospitals for beneficiary discharges that were coded as discharges to a swing bed in another hospital. Swing beds are inpatient beds that can be used interchangeably for either acute care or skilled nursing services. Pursuant to Federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. (42 CFR § 412.4 (e).) In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another prospective payment system (PPS) hospital (42 CFR § 412.4(f).) This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged "early" and then admitted to additional care in other clinical settings. However, Medicare does not pay the reduced graduated per diem rate if that patient was discharged to a swing bed in another hospital. If appropriate, we will recommend that CMS evaluate its policy related to payment for hospital discharges to swing beds in other hospitals. *(OAS; W-00-13-35700; various reviews; expected issue date: FY 2013; new start)*

Hospitals—Acute-Care Inpatient Transfers to Inpatient Hospice Care

We will determine the extent to which acute care hospitals discharge beneficiaries after a short stay to hospice facilities. Analysis of Medicare claims data demonstrates significant occurrences of a discharge from an acute care hospital after a short stay that is immediately followed by hospice care. Medicare pays a full PPS rate to hospitals that discharge beneficiaries for hospice care (42 CFR § 412.4(e). In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another PPS hospital or, for certain DRGs, to postacute care settings, such as a skilled nursing facility. (42 CFR § 412.4(f).) This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged "early" and then admitted for additional care in other clinical settings. If appropriate, we will recommend that CMS evaluate its policy related to payment for hospital discharges to hospice facilities. *(OAS; W-00-12-35602; various reviews; expected issue date: FY 2013; work in progress)*

Hospitals—Payments for Canceled Surgical Procedures (New)

We will determine costs incurred by Medicare related to inpatient hospital claims for canceled surgical procedures. Our preliminary analysis of Medicare claims data for inpatient stays demonstrated significant occurrences of an initial PPS payment to hospitals for a canceled surgical procedure followed

by a second, higher PPS payment to the same hospitals for the rescheduled surgical procedure. For these claims, the canceled surgical procedure was the principal reason for the initial hospital admission. For these short-stay claims, few, if any, inpatient services (i.e., laboratory or diagnostic tests) were provided by the hospitals because the surgical procedure was canceled. Medicare makes two payments to hospitals that generate two bills unless the patient is readmitted to the hospital on the same day, in which case a single payment is made. Our analysis also identified inpatient claims with canceled surgical procedures for stays of less than 2 days that were not followed by subsequent inpatient admissions to the same hospitals for the rescheduled surgical procedures. Current Medicare policy does not preclude payment for these claims. *(OAS; W-00-13-35626; various reviews; expected issue date: FY 2013; new start)*

Hospitals—Payments for Mechanical Ventilation (New)

We will review Medicare payments for mechanical ventilation to determine whether the DRG assignments and resultant payments were appropriate. We will review selected Medicare payments to determine whether patients received fewer than 96 hours of mechanical ventilation. Mechanical ventilation is the use of a ventilator or respirator to take over active breathing for a patient. CMS requires that claims be completed accurately to be processed correctly and promptly. (*Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 1, § 80.3.2.2.) For certain DRG payments to qualify for Medicare coverage, a patient must receive 96 or more hours of mechanical ventilation. *(OAS; W-00-12-35575; various reviews; expected issue date: FY 2013; work in progress)*

Hospitals—Admissions With Conditions Coded Present on Admission

We will review Medicare claims to determine whether specific acute care hospitals are frequently transferring patients with certain diagnoses that were coded as being present when patients were admitted (referred to as "present on admission" (POA)) to another acute care hospital. Medicare requires acute care hospitals to report on their claims which diagnoses were present when patients were admitted. (Social Security Act, § 1886(d)(4)(D), and CMS's *Change Request 5679*, Pub. 100-20, One-Time Notification, Transmittal 289.) *(OAS; W-00-12-35500; various reviews; expected issue date: FY 2013; work in progress)*

Hospitals—Inpatient and Outpatient Payments to Acute Care Hospitals

We will review Medicare payments to hospitals to determine compliance with selected billing requirements. We will use the results of these reviews to recommend recovery of overpayments and identify providers that routinely submit improper claims. Prior OIG audits, investigations, and inspections have identified areas at risk for noncompliance with Medicare billing requirements. Using computer matching and data mining techniques, we will select hospitals for focused reviews of claims that may be at risk for overpayments. Using the same techniques, we will identify hospitals that broadly rank as least risky across compliance areas and those that broadly rank as most risky. We will then review the hospitals' policies and procedures to compare the compliance practices of these two groups of hospitals. We will also survey or interview hospitals' leadership and compliance officers to provide

contextual information related to hospitals' compliance programs. *(OAS; W-00-11-35538; W-00-12-35538; various reviews; expected issue date: FY 2013; work in progress)*

Hospitals—Inpatient Outlier Payments: Trends and Hospital Characteristics

We will review hospital inpatient outlier payments, examine trends of outlier payments nationally, and identify characteristics of hospitals with high or increasing rates of outlier payments. Medicare typically reimburses hospitals for inpatient services based on a predetermined per-discharge amount, regardless of the actual costs incurred. Medicare pays hospitals supplemental payments, called outlier payments, for patients incurring extraordinarily high costs. (Social Security Act, § 1886(d)(5)(A)(ii).) 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. *(OEI; 06-10-00520; expected issue date: FY 2013; work in progress)*

Hospitals—Reconciliations of Outlier Payments

We will review Medicare outlier payments to determine whether CMS performed the necessary reconciliations in a timely manner so that Medicare contractors could perform final settlement of the associated cost reports submitted by providers. We will also examine whether MACs referred all providers that meet the criteria for reconciliations to CMS. Outliers are additional payments made for beneficiaries who incur unusually high costs. Outlier payment reconciliations must be based on the most recent cost-to-charge ratio from the cost report to properly determine outlier payments. (42 CFR § 412.84(i)(4).) Outlier payments also may be adjusted to reflect the time value of money for overpayments and underpayments. *(OAS; W-00-11-35451; W-00-12-35451; W-00-13-35451; various reviews; expected issue date: FY 2013; work in progress and new start)*

Hospitals—Quality Improvement Organizations' Work With Hospitals (New)

We will determine the extent to which Quality Improvement Organizations (QIO) worked with hospitals either to conduct quality improvement projects or to provide technical assistance. We will also assess the barriers QIOs experience when engaging hospitals. CMS is required to enter into contracts with QIOs, formerly called utilization and quality control peer review organizations. (Social Security Act § 1862 (g).) The purpose of the QIOs is to improve the efficiency, effectiveness, economy, and quality of services delivered to Medicare beneficiaries. Medicare spends about $1.1 billion for each 3-year QIO contract period, and each contract calls for QIOs to provide technical assistance to providers and specifies clinical areas for the quality improvement projects. *(OEI; 01-12-00650; expected issue date: FY 2014; work in progress)*

Hospitals—Duplicate Graduate Medical Education Payments

We will review provider data from CMS's Intern and Resident Information System (IRIS) to determine whether duplicate or excessive graduate medical education (GME) payments have been claimed. We will also assess the effectiveness of IRIS in preventing providers from receiving payments for duplicate GME costs. Medicare pays teaching hospitals for direct graduate medical education

(DGME) and indirect medical education (IME) costs. In the calculation of payments for DGME and IME costs, no intern or resident may be counted by Medicare as more than one full-time-equivalent (FTE) employee. (42 CFR §§ 413.78(b) and 412.105(f)(1)(iii).) The primary purpose of IRIS 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. *(OAS; W-00-13-35432; various reviews; expected issue date: FY 2013; new start)*

Hospitals—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 and the effect on Medicare of inaccurate reporting of occupational-mix data. Hospitals must accurately report data every 3 years on the occupational mix of their employees. (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 PPS for hospitals. *(OAS; W-00-13-35452; various reviews; expected issue date: FY 2013; new start)*

Hospitals—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. Medicare does not cover items or services for which neither the beneficiary nor anyone on his or her behalf has an obligation to pay. (Social Security Act, §1862(a)(2).) 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. Medicare requires hospitals 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-00-13-35516; various reviews; expected issue date: FY 2013; new start)*

Hospitals—Outpatient Dental Claims

We will review Medicare hospital outpatient payments for dental services to determine whether such payments were made in accordance with Medicare requirements. Dental services are generally excluded from Medicare coverage, with a few exceptions. (Social Security Act, § 1862(a)(12).) For example, Medicare reimbursement is allowed for the extraction of teeth to prepare the jaw for radiation treatment (CMS's *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 15, § 150). As indicated by current OIG audits, providers received Medicare reimbursement for noncovered dental services, which resulted in significant overpayments. *(OAS; W-00-13-35603; various reviews; expected issue date: FY 2013; new start)*

Hospitals—Outpatient Observation Services During Outpatient Visits

We will describe the use of observation services from 2008 to 2011 and the characteristics of beneficiaries receiving observation services in 2011. We will also determine how much Medicare and

beneficiaries paid for observation and related services in 2011 and the extent to which hospitals inform beneficiaries about observation services. Part B coverage of hospital outpatient services and reimbursement for such services under the hospital outpatient PPS are provided by the Social Security Act, §§ 1832(a) and 1833(t).) Observation services are short-term treatments and assessments that hospitals use to determine whether a beneficiary should be admitted as an inpatient or discharged. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 4, § 290.) Improper use of observation services may subject beneficiaries to high cost sharing. *(OEI; 02-12-00040; expected issue date: FY 2013; work in progress)*

Hospitals—Acquisitions of Ambulatory Surgical Centers: Impact on Medicare Spending (New)

We will determine the extent to which hospitals acquire ASCs and convert them to hospital outpatient departments. We will also determine the effect of such acquisitions on Medicare payments and beneficiary cost sharing. Medicare reimburses outpatient surgical services performed in hospital outpatient departments at a higher rate than similar services performed in ASCs. Hospitals may be acquiring ASCs and providing outpatient surgical services in that setting. *(OEI; 06-12-00590; expected issue date: FY 2014; work in progress)*

Critical Access Hospitals— Variations in Size, Services, and Distance From Other Hospitals

We will review CAHs to profile variations in size, services, and distance from other hospitals. We will also examine the numbers and types of patients that critical access hospitals (CAH) treat. To be designated as CAHs, hospitals must meet several criteria, such as being located in a rural area, furnishing 24-hour emergency care, providing no more than 25 inpatient beds; and having an average annual length of stay of 96 hours or less. (Social Security Act, § 1820(c)(2)(B).) CAHs are a separate provider type with their own Medicare CoP and payment method. There are approximately 1,350 CAHs, but information about their structure and services is limited. *(OEI; 05-12-00080; expected issue date: FY 2013; work in progress)*

Critical Access Hospitals—Payments for Swing-Bed Services (New)

We will compare reimbursement for swing-bed services at CAHs to the same level of care obtained at traditional skilled nursing facilities (SNF) to determine whether Medicare could achieve cost savings through a more cost effective payment methodology. Swing beds are inpatient beds that can be used interchangeably for either acute care or skilled nursing services. The Balanced Budget Act of 1997 (BBA) created the CAH Program to ensure access to health care services in rural areas. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) allowed CAHs to receive Medicare reimbursement equal to 101 percent of reasonable cost and have up to 25 inpatient beds that could be used for acute care or swing-bed services, with CMS approval. (Social Security Act, § 1814(l).) Neither the BBA nor the MMA established any length-of-stay limits for swing-bed utilization. Unlike CAHs, traditional SNFs are reimbursed under a PPS through case-mix, adjusted per-diem prospective payment rates for all SNFs. The payment rates represent payment in full for all costs associated with

furnishing covered SNF services to Medicare beneficiaries. *(OAS; W-00-12-35101; various reviews; expected issue date: FY 2013; work in progress)*

Inpatient Rehabilitation Facilities—Transmission of Patient Assessment Instruments

We will determine whether IRFs 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 provide that they be reduced if patient assessments are not encoded and transmitted within defined time limits. (42 CFR § 412.614(d)(2).) 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-00-11-35522; various reviews; expected issue date: FY 2013; work in progress)*

Inpatient Rehabilitation Facilities—Appropriateness of Admissions and Level of Therapy

We will examine the appropriateness of admissions to IRFs. We will also examine the level of therapy provided in IRFs and how much concurrent and group therapy IRFs provide. IRFs provide rehabilitation for patients who require a hospital level of care, including a relatively intense rehabilitation program and a multidisciplinary, coordinated team approach to improve patients' ability to function. Patients must undergo preadmission screening and evaluation to ensure that they are appropriate candidates for IRF care. (42 CFR §§ 412.622(a)(3)-(5).) *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Long -Term-Care Hospitals—Payments for Interrupted Stays (New)

We will determine the extent to which Medicare made improper payments for interrupted stays in long-term -care hospitals (LTCH) in 2011. We will also identify readmission patterns and determine the extent to which LTCHs readmit patients directly following the interrupted stay periods. LTCHs are generally defined as inpatient acute care hospitals with an average length of stay greater than 25 days. An interrupted stay occurs when a patient is discharged from an LTCH for treatment and services that are not available at the LTCH and is readmitted after a specific number of days. Interrupted stays in LTCHs cause an adjustment in Medicare payments. (42 CFR § 412.531.) Prior OIG work has identified vulnerabilities in CMS's ability to detect readmissions and appropriately pay for interrupted stays. *(OEI; 04-12-00490; expected issue date: FY 2014; work in progress)*

Nursing Homes

Acronyms and Abbreviations for Selected Terms Used in This Section:

IRF—inpatient rehabilitation facility
RAI—Resident Assessment Instrument
SNF—skilled nursing facility

Nursing Homes—Adverse Events in Post-Acute Care for Medicare Beneficiaries

We will estimate the national incidence of adverse and temporary harm events for Medicare beneficiaries receiving postacute care in SNFs and inpatient rehabilitation facilities (IRF). We will also identify contributing factors to these events, determine the extent to which the events were preventable, and estimate the associated costs to Medicare. Medicare Part A pays for up to 100 days of care in SNFs and IRFs following a hospital stay of at least 3 days and in cases when a medical professional verifies the need for nursing care and rehabilitation related to the hospitalization. SNFs are the primary providers of postacute care, admitting 85 percent of Medicare beneficiaries receiving facility care following a hospitalization. Medicare expenditures for SNF care have more than doubled in the last decade; Medicare paid $12 billion for SNF care in 2000 and $28 billion in 2011. IRFs provide a far smaller percentage of postacute facility care (11 percent) but like SNFs have experienced rapid growth over the last decade and accounted for $7 billion in Medicare expenditures in 2011. *(OEI; 06-11-00370; expected issue date: FY 2014; work in progress)*

Nursing Homes—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 use the Residential Assessment Instruments (RAI) to develop care plans to provide services to beneficiaries in accordance with the plans of care and to plan for beneficiaries' discharges. We will also describe any instances of poor quality of care . Prior OIG reports revealed that about a quarter of residents' needs for care, as identified through RAIs, were not reflected in care plans and that nursing home residents did not receive all the psychosocial services identified in care plans. Federal laws require nursing homes participating in Medicare or Medicaid to use RAIs to assess each nursing home resident's strengths and needs. (Social Security Act, §§ 1819(b)(3) and 1919(b)(3).) *(OEI; 02-09-00201; expected issue date: FY 2013; work in progress)*

Nursing Homes—State Agency Verification of Deficiency Corrections (New)

We will determine whether State survey agencies verified correction plans for deficiencies identified during nursing home recertification surveys. Federal regulations require nursing homes to submit correction plans to the State survey agency or CMS for deficiencies identified during surveys. (42 CFR § 488.402(d).) CMS requires State survey agencies to verify the correction of identified deficiencies through onsite reviews or by obtaining other evidence of correction. (*State Operations Manual*, Pub. No. 100-07, § 7300.3.) A prior OIG review found that one State survey agency did not always verify that nursing homes corrected deficiencies identified during surveys in accordance with Federal requirements. *(OAS; W-00-13-35701; various reviews; expected issue date: FY 2013; new start)*

Nursing Homes—Oversight of Poorly Performing Facilities

We will identify poorly performing nursing homes and determine the extent to which CMS and States use enforcement measures to improve nursing home performance. We will also identify CMS and States' followup actions to ensure that poorly performing nursing homes implement corrective actions. Federal requirements include a survey-and-certification process, with associated enforcement measures, to ensure that nursing homes meet Federal standards for participation in Medicare and

Medicaid. (Social Security Act, §§ 1819(g) and 1864.) We will examine enforcement decisions by CMS and States resulting from surveys and complaint allegations. *(OEI; 06-12-00120; expected issue date: FY 2014; work in progress)*

Nursing Homes—Use of Atypical Antipsychotic Drugs (New)

We will assess nursing homes' administration of atypical antipsychotic drugs, including the percentage of residents receiving these drugs and the types of drugs most commonly received. We will also describe the characteristics associated with nursing homes that frequently administer atypical antipsychotic drugs. According to 42 CFR § 488.3, nursing homes must comply with Federal quality and safety standards, including requiring the monitoring of the prescription drugs prescribed to its residents. Federal requirements, 42 CFR § 483.25(l)(1), also require that nursing home residents' drug regimens be free from unnecessary drugs. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Nursing Homes—Hospitalizations of Nursing Home Residents

We will determine the extent to which Medicare beneficiaries residing in nursing homes have been hospitalized. We will also determine the extent to which hospitalizations were a result of manageable or preventable conditions. Hospitalizations of nursing home residents are costly to Medicare and may indicate quality-of-care problems at nursing homes. A 2007 OIG review found that 35 percent of hospitalizations during a SNF stay were caused by poor quality of care or unnecessary fragmentation of services. *(OEI; 06-11-00040; expected issue date: FY 2013; work in progress)*

Nursing Homes—Questionable Billing Patterns for Part B Services During Nursing Home Stays

We will identify questionable billing patterns associated with nursing homes and Medicare providers for Part B services provided to nursing home residents. Part B services provided during a nursing home stay must be billed directly by suppliers and other providers. (CMS's *Medicare Benefits Policy Manual*, Pub. 100-02, ch. 8, § 70.) Congress directed OIG to monitor these services for abuse. (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), § 313.) A series of studies will examine podiatry, ambulance, laboratory, and imaging services. *(OEI; 06-11-00280; various reviews; expected issue dates: FY 2013; work in progress)*

Nursing Homes—Oversight of the Minimum Data Set Submitted by Long-Term-Care Facilities (New)

We will determine whether and the extent to which CMS and the States oversee the accuracy and completeness of Minimum Data Set (MDS) data submitted by nursing facilities. Certified nursing facilities are required to complete the MDS for all residents at specified intervals and submit data electronically to the State. States then submit data to CMS, which uses it for a number of programs, including payment, quality monitoring, and consumer information. *(OEI; 06-12-00440; expected issue dates: FY 2014; work in progress)*

Hospices

Acronyms and Abbreviations for Selected Terms Used in This Section:

MedPAC—Medicare Payment Advisory Commission
CoPs—(Medicare) conditions of participation

Hospices—Marketing Practices and Financial Relationships with Nursing Facilities

We will review hospices' marketing materials and practices and their financial relationships with nursing facilities. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. (Social Security Act, § 1812(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, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also highlighted instances in which hospices aggressively marketed services to nursing facility residents. We will focus our review on hospices that have a high percentage of their beneficiaries in nursing facilities. *(OEI; 02-10-00071; 02-10-00072; expected issue date: FY 2013; work in progress)*

Hospices—General Inpatient Care

We will review the use of hospice general inpatient care in 2011. We will also assess the appropriateness of hospices' general inpatient care claims. Federal regulations address Medicare CoPs for hospice at 42 CFR Part 418. We will review hospice medical records to address concerns that this level of hospice care is being misused. *(OEI; 02-10-00490; expected issue date: FY 2013; work in progress)*

Home Health Services

Acronyms and Abbreviations for Selected Terms Used in This Section:

CoP—(Medicare) conditions of participation
HHA—home health agency
OASIS—Outcome and Assessment Information Set
PPS—prospective payment system

HHAs—Home Health Face-to-Face Requirement (New)

We will determine the extent to which home health agencies (HHA) are complying with a statutory requirement that physicians (or certain practitioners working with physicians) who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries. (Patient Protection and Affordable Care Act (Affordable Care Act), § 6407.) The encounters must occur within 120 days: either within the 90 days before beneficiaries start home health care or up to 30 days after care begins. (42 CFR § 424.22.) OIG work conducted before the Affordable Care Act mandate went into effect found that only 30 percent of beneficiaries had at least one face-to-face visit with the

physicians who ordered their home health care. *(OEI; 01-12-00390; expected issue date: FY 2013; work in progress. Affordable Care Act.)*

HHAs—Employment of Home Health Aides With Criminal Convictions (New)

We will determine the extent to which HHAs are complying with State requirements that criminal background checks be conducted with respect to HHA applicants and employees. Federal law requires that HHAs comply with all applicable State and local laws and regulations. (Social Security Act, §1891(a)(5), implemented at 42 CFR § 484.12(a).) A previous OIG review found that 92 percent of nursing homes employed at least one individual with at least one criminal conviction; however, this review could not determine whether the nursing home employees were disqualified from working in nursing homes because OIG did not have access to detailed information on the nature of the employees' crimes. Nearly all States have laws prohibiting certain care-related entities from employing individuals with prohibited criminal convictions. *(OEI; 12-12-00630; expected issued date: FY 2013; work in progress)*

HHAs—States' Survey and Certification: Timeliness, Outcomes, Followup, and Medicare Oversight

We will review the timeliness of HHA recertification and complaint surveys conducted by State Survey Agencies and Accreditation Organizations, the outcomes of those surveys, and the followup of complaints against HHAs. We will also look at CMS oversight designed to monitor HHA surveys. CMS relies on the survey and certification process to ensure HHA compliance with Medicare CoPs. HHAs must be surveyed at least every 36 months. (Social Security Act, § 1891(c)(2).) Regulations on surveys to validate the accreditation process are at 42 CFR § 488.8, and instructions on surveys to monitor State Survey Agencies' performance are in CMS's *State Operations Manual*, §§ 4157 and 4158. *(OEI; 06-11-00400; expected issue date: FY 2013; work in progress)*

HHAs—Missing or Incorrect Patient Outcome and Assessment Data

We will review home health agencies Outcome and Assessment Information Set (OASIS) data to identify payments for episodes for which OASIS data were not submitted or for which the billing codes on the claims are inconsistent with OASIS data. OASIS data are electronically submitted to CMS, independently of the home health agency's claim for episode payment. Federal regulations require that HHAs submit OASIS data as a condition for payment. (42 CFR § 484.210(e).) HHAs receive prospective payments on the basis of 60-day episodes of care. The OASIS is a standard set of data items used to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services and includes the billing code for the episode of care. *(OAS; W-00-13-35600; various reviews; expected issue date: FY 2013; new start)*

HHAs—Medicare Administrative Contractors' Oversight of Claims

We will review the activities that CMS and its contractors performed to identify and prevent improper home health payments from January to October 2011. We will also determine the extent to which CMS and its contractors performed activities to identify and address potential fraud among HHAs. In 2010, Medicare paid approximately $19.5 billion to 11,203 HHAs for services provided to 3.4 million

beneficiaries. Previous OIG and the Department of Justice (DOJ) investigations indicate that the home health benefit may be susceptible to fraud. *(OEI; 04-11-00220; expected issue date: FY 2013; work in progress)*

HHAs—Home Health Prospective Payment System Requirements

We will review compliance with various aspects of the home health PPS, including the documentation required in support of the claims paid by Medicare. Some beneficiaries who are confined to their homes are eligible to receive home health services. (Social Security Act, §§ 1835(a)(2)(A) and 1861(m).) Such services include part-time or intermittent skilled nursing care, as well as other skilled care services, such as physical, occupational, and speech therapy; medical social work; and home health aide services. *(OAS; W-00-12-35501; W-00-13-35501; various reviews; expected issue date: FY 2013 ;work in progress and new start)*

HHAs—Trends in Revenues and Expenses

We will review cost report data to analyze HHA revenue and expense trends under the home health PPS to determine whether the payment methodology should be adjusted. We will examine various Medicare and overall revenue and expense trends for freestanding and hospital-based HHAs. Since the home health PPS was implemented in October 2000, HHA expenditures have significantly increased. Home health services are paid under a PPS pursuant to the Social Security Act, § 1895, added by the Balanced Budget Act of 1997 (BBA), § 4603. *(OAS; W-00-10-35428; various reviews; expected issue date: FY 2013; work in progress)*

Medical Equipment and Supplies

Acronyms and Abbreviations for Selected Terms Used in This Section:

CBA—Competitive Bidding Areas
CPAP—continuous positivie airway pressure (machine)
LCD—local coverage determination
PMD—power mobility device

Quality Standards—Accreditation of Medical Equipment Suppliers (New)

This review will examine accreditation organizations' (AO) requirements and processes for granting accreditation to ensure that medical equipment suppliers meet each of Medicare's quality standards. Failure to meet quality standards could pose a threat to beneficiary safety and quality of care as well as place Medicare resources at risk. Medical equipment suppliers must become accredited by a CMS-approved AO and must comply with quality standards to maintain their billing privileges. CMS oversees AOs through validation surveys. This review will also evaluate CMS's procedures for conducting validation surveys. Such surveys help CMS determine whether an AO's accreditation procedures are adequately ensuring that suppliers are complying with Medicare's quality standards. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Program Integrity—Reliability of Service Code Modifiers on Medical Equipment Claims

We will determine the appropriateness of Part B payments that Medicare made on the basis of specific service code modifiers that suppliers entered on the claims. Such modifiers indicate that suppliers have required supporting documentation on file. Suppliers must provide, upon request, the documentation to support the claims for payment. Payments to service providers are precluded unless the provider maintains and furnishes upon request the information necessary to determine the amounts due. (Social Security Act, § 1833(e).) Reviews of suppliers conducted by Medicare claims processing contractors found that suppliers had little or no documentation to support their claims, suggesting that many of the claims submitted may have been improper and should not have been paid by Medicare. *(OAS; W-00-11-35305; W-00-12-35305; various reviews; expected issue date: FY 2013; work in progress)*

Program Integrity—Use of Surety Bonds To Recover Medical Equipment Supplier Overpayments

We will review CMS's use of surety bonds to recover overpayments made to medical equipment suppliers. We will determine the extent to which CMS maintains complete and accurate surety bond information for medical equipment suppliers. We will also determine the number of medical equipment suppliers with overpayment debt, the extent to which these suppliers had surety bond coverage, and the amount of overpayment debt that could have been recovered through surety bonds since October 2009. Certain medical equipment suppliers must provide and maintain a surety bond of no less than $50,000. (Balanced Budget Act of 1997 (BBA), § 4312(a)(16).) By requiring medical equipment surety bonds, CMS aims to limit fraud risk to Medicare by ensuring only legitimate suppliers are enrolled and to recoup overpayments resulting from fraudulent or abusive billing practices. *(OEI; 03-11-00350; expected issue date: FY 2013; work in progress)*

Lower Limb Prostheses—Supplier Compliance With Payment Requirements (New)

We will review Medicare Part B payments for claims submitted by medical equipment suppliers for lower limb prosthetics to determine whether the requirements of CMS's *Benefits Policy Manual*, Pub. 100-02, ch. 15, § 120, were met. Payments to service providers are precluded unless the provider has and furnishes upon request the information necessary to determine the amounts due. (Social Security Act, §1833(e).) Medicare does not pay for items or services that are "not reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) OIG conducted a national review of suppliers of lower limb prosthetics and identified 267 suppliers that had questionable billings. Prior OIG work found that suppliers frequently submitted claims that did not meet certain Medicare requirements; were for beneficiaries with no claims from their referring physicians; and had other questionable billing characteristics (e.g., billing lower limb prostheses for a high percentage of beneficiaries with no history of an amputation or missing limb). Such claims are improper and should not be paid by Medicare. *(OAS; W-00-13-35702; various reviews; expected issue date: FY 2013; new start)*

Power Mobility Devices—Supplier Compliance With Payment Requirements (New)

We will conduct a series of reviews related to power mobility devices (PMD). The reviews will focus on whether Medicare payments for PMD claims submitted by medical equipment suppliers were made in

accordance with requirements at 42 CFR § 410.38(c)(2). Medicare does not pay for items or services that are "not reasonable and necessary." We will also determine whether savings can be achieved by Medicare for PMDs that are not affected by the Affordable Care Act, § 3136, which eliminated the option of a lump-sum purchase for certain PMDs. Prior to the enactment of the Affordable Care Act, a beneficiary was given the option to make a "lump sum" purchase of a power-driven wheelchair at the time it was furnished instead of renting it. *(OAS; W-00-13-35703; various reviews; expected issue date: FY 2013; new start. Affordable Care Act.)*

Vacuum Erection Systems—Reasonableness of Medicare's Fee Schedule Amounts Compared to Amounts Paid by Other Payers (New)

Our review will determine the reasonableness of the Medicare fee schedule amount for Vacuum Erection Systems (VES). We will compare Medicare payments made for VES to the amounts paid by non-Medicare payers, such as private insurance companies and the Department of Veterans Affairs (VA), to identify potentially wasteful spending. We will estimate the financial impact on the Medicare program and on beneficiaries of aligning the fee schedule payments for VESs with those of non-Medicare payers. *(OAS; W-00-13-35705; various reviews; expected issue date: FY 2013; new start)*

Back Orthoses—Reasonableness of Medicare Payments Compared to Supplier Acquisition Costs

We will compare Medicare reimbursement amounts for the back orthosis procedure code L0631 to supplier acquisition costs to evaluate the reasonableness of Medicare's spending. Back orthoses, which are covered by Social Security Act, § 1832(a)(2), are supplied by Medicare medical equipment suppliers who purchase them from wholesalers or directly from orthotics manufacturers. For 2011, the median Medicare reimbursement amount for an L0631 back brace was $929. OIG has encountered suppliers who can purchase these back orthoses for prices significantly lower than Medicare reimbursement rates. Internet retail prices for back orthoses are also significantly lower than Medicare pays. *(OEI; 03-11-00600; expected issue date: FY 2013; work in progress)*

Parenteral Nutrition—Reasonableness of Medicare Payments Compared to Payments by Other Payers

We will compare Medicare's fee schedule for parenteral nutrition with fees paid by other sources of reimbursement to evaluate the reasonableness of Medicare's spending. We will identify reimbursement amounts paid by public and private payers for parenteral nutrition services. Parenteral nutrition is the practice of feeding a person intravenously to replace the function of a permanently inoperative or malfunctioning internal 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 (HMO), and 11 times higher than some manufacturers' contract prices. *(OEI; 04-12-00640; expected issue date: FY 2014; work in progress)*

Frequently Replaced Supplies—Supplier Compliance With Medical Necessity, Frequency, and Other Requirements

We will review claims for frequently replaced medical equipment supplies to determine whether medical necessity, frequency, and other Medicare requirements are met. For supplies and accessories used periodically, orders or certificates 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 Program Integrity Manual*, Pub. 100-08, ch. 5, §§ 2.3 and 5.9.) Beneficiaries or their caregivers must specifically request refills of repetitive services and/or supplies before suppliers dispense them. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 20, § 200.) Suppliers may not initiate refills of orders, and suppliers must not automatically dispense a quantity of supplies on a predetermined regular basis. Medicare does not pay for items or services that are "not reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) Prior OIG work found that suppliers automatically shipped continuous positive airway pressure system and respiratory-assist device supplies when no physician orders for refills were in effect. Such claims are improper and should not be submitted to Medicare for payment.
(OAS; W-00-13-35240; various reviews; expected issue date: FY 2013; new start)

Continuous Positive Airway Pressure Supplies—Reasonableness of Medicare's Replacement of Supplies Compared to That of Other Federal Programs (New)

We will determine the extent to which Medicare's supply replacement schedules for supplies related to continuous positive airway pressure (CPAP) machines (equipment used to treat obstructive sleep apnea) vary from those of Medicaid, VA, and Federal Employees Health Benefits programs. We will also identify savings that might be achieved by adopting alternative schedules to avoid wasteful spending. Medicare Part B covers medical equipment and the services and supplies that are essential to its effective use . Separate charges for replacement supplies, such as masks, tubing, and filters, are covered if a beneficiary either rents or owns a CPAP machine. There are no national coverage determinations for the frequency of replacement of CPAP supplies; rather, this is at the discretion of designated Medicare payment contractors. The contractors have established identical CPAP supply replacement schedules.
(OEI; 07-12-00250; expected issue date: FY 2013; work in progress)

Diabetes Testing Supplies—Supplier Compliance With Payment Requirements for Blood Glucose Test Strips and Lancets

We will review Medicare Part B payments for home blood glucose test strips and lancet supplies to determine their appropriateness. The local coverage determinations (LCD) issued by the four Medicare contactors that process medical equipment and supply claims 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 code 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 service code modifier. Medicare does not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).)
(OAS; W-00-11-35407; W-00-12-35407; various reviews; expected issue date: FY 2013; work in progress)

Diabetes Testing Supplies —Effectiveness of System Edits To Prevent Inappropriate Payments for Blood-Glucose Test Strips and Lancets to Multiple Suppliers

We will review Medicare's claims processing edits (special system controls) designed to prevent payments to multiple suppliers of home blood-glucose test strips and lancets and determine whether they are effective in preventing inappropriate payments. The LCDs issued by the pertinent claims processing contractors state that medical equipment suppliers may not dispense test strips and lancets until beneficiaries have nearly exhausted the previously dispensed supplies. The LCDs also require that beneficiaries or their caregivers must specifically request the refills before the suppliers dispense them. Prior OIG work found that inappropriate payments were made to multiple medical equipment suppliers for test strips and lancets dispensed to the same beneficiary with overlapping service dates. Medicare does not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) *(OAS; W-00-13-35604; various reviews; expected issue date: FY 2013; new start)*

Diabetes Testing Supplies—Potential Questionable Billing for Test Strips in 2011

We will review Medicare claims data from 2011 to identify suppliers with inappropriate payments and/or questionable billing for diabetes test strips. We will also analyze the geographic location of suppliers that had questionable billing and the extent to which the suppliers were associated with claims for beneficiaries residing in competitive bidding areas in 2011. Recent investigations and prior Office of Inspector General studies have found that diabetes test strips are vulnerable to improper claims, fraud, waste, and abuse. *(OEI; 04-11-00330; expected issue date: FY 2013; work in progress)*

Diabetes Testing Supplies—Improper Supplier Billing for Test Strips in Competitive Bidding Areas (New)

We will determine the extent to which suppliers improperly billed Medicare non-mail-order diabetes test strips in Competitive Bidding Areas (CBA) in 2011. We will also describe billing trends for test strips in CBAs between 2010 and 2011 and the extent to which suppliers conducted activities that we determined to be inappropriate (i.e., waiving copayments, contacting beneficiaries, sending unsolicited test strips in 2010 or 2011. There is concern that suppliers may be undermining the Competitive Bidding Program by billing for non-mail order test strips that are actually provided via mail order to receive a higher reimbursement amount and/or may be providing incentives to beneficiaries to receive test strips via non-mail order rather than via mail order, such as by waiving Medicare Part B copayments for beneficiaries. In 2011, the Competitive Bidding Program started in nine CBAs, resulting in lower reimbursement rates for mail-order test strips than for non-mail-order test strips. *(OEI; 04-11-00760; expected issue date: FY 2013; work in progress)*

Diabetes Testing Supplies—Supplier Compliance With Requirements for Non-Mail-Order Claims (New)

We will determine whether Part B payments for non-mail-order diabetes testing supplies (e.g., supplies purchased from suppliers that have physical locations) were made in accordance with Medicare requirements. Federal law required a 9.5-percent reduction in fee schedule payments for certain items included in Round 1 of the Durable Medicare Equipment, Prosthetics, Orthotics, and Supplies

Competitive Bidding Program, including diabetic testing supplies delivered by mail. (Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), § 154(a)(2).) The reduction applied to items provided on or after January 1, 2009, in any geographical area. Suppliers are required to use the service code "KL" modifier on claims for such supplies delivered to Medicare beneficiaries by mail (e.g., common carrier). Claims with the KL modifier are paid at the lower rate. We will review claims billed without KL modifiers to confirm whether the resulting higher payments were proper. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 36, § 20.5.4.1.) *(OAS; W-00-13-35704; various reviews; expected issue date: FY 2013; new start)*

Competitive Bidding—Mandatory Review

We will review the process CMS used to conduct competitive bidding and to make subsequent pricing determinations for certain medical equipment items and services in selected competitive bidding areas under rounds 1 and 2 of the competitive bidding program. Federal law requires OIG to conduct postaward audits to assess this process. (Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), § 154(a)(1)(E).) *(OAS; W-00-12-35241; W-00-13-35241; various reviews; expected issued date: FY 2013; work in progress and new start)*

Other Providers and Suppliers

Acronyms and Abbreviations for Selected Terms Used in This Section:

ASC—ambulatory surgical center
CERT—Comprehensive Error Rate Testing (program)
E/M—evaluation and management (services)
ESRD—end stage renal disease
HOPD—hospital outpatient department
PHP—partial hospitalization program
POD—physician-owned distributor
PPS—prospective payment system
RHC—rural health clinic

Program Integrity—Onsite Visits for Medicare Provider and Supplier Enrollment and Reenrollment (New)

We will determine how often onsite visits occur as part of the Medicare enrollment or reenrollment process. CMS reserves the right, when deemed necessary, to perform onsite inspections of a provider or supplier to verify enrollment information submitted to CMS. (42 CFR § 424.510(d)(8).) Moreover, CMS is authorized to expand the role of unannounced preenrollment site visits. (Affordable Care Act, § 6401(a)(3).) CMS implemented the Affordable Care Act provider and enrollment provisions by requiring onsite visits for provider and supplier types identified by CMS as moderate risk or high risk. (76 Fed. Reg. 5862 (February 2, 2011).) A prior OIG review found that 33 percent of medical equipment suppliers in South Florida did not maintain physical facilities, a vulnerability that might be reduced by confirming legitimacy of location with onsite visits conducted during the enrollment process. *(OEI; 00-00-00000; expected issue date: FY 2014; new start. Affordable Care Act.)*

Program Integrity—Medical Review of Part A and Part B Claims Submitted by Top Error-Prone Providers

We will review Medicare Part A and Part B claims submitted by error-prone providers to determine their validity, project our results to each provider's population of claims, and recommend that CMS request refunds on projected overpayments. 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 over a 4-year period. In this review, we will select the top error-prone providers on the basis of expected dollar error amounts and match the 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. Providers must submit accurate claims for services provided to Medicare beneficiaries. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04.) *(OAS; W-00-13-35565; various reviews; expected issue date: FY 2013; new start)*

Program Integrity—Improper Use of Commercial Mailboxes (New)

We will determine the extent to which Medicare Part B providers and suppliers had practice locations that matched commercial mailbox addresses in 2011. Medicare providers and suppliers are required to establish physical business facilities of adequate size and with permanent, visible signs and must provide CMS with specific street addresses (not mailboxes) recognized by the U. S. Postal Service. Recent evidence suggests that individuals attempting to defraud Medicare may be using mailbox rental services to evade enforcement of this requirement, as commercial mailbox services provide a recognized street address without a mailbox number. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Program Integrity—Payments to Providers Subject to Debt Collection (New)

We will review providers and suppliers that received Medicare payments after CMS referred them to the Department of the Treasury (Treasury) for failure to refund overpayments. We will determine the extent to which they ceased billing under one Medicare provider number but billed Medicare under a different number after being referred to Treasury. CMS may deny a provider's or supplier's enrollment in the Medicare program if the current owner, physician, or nonphysician practitioner has an existing overpayment at the time of filing an enrollment application. Federal law requires CMS to seek the recovery of all identified overpayments. The Debt Collection Improvement Act of 1996 (DCIA) requires Federal agencies to refer eligible delinquent debt to Treasury for appropriate action. (42 CFR § 424.530(a)(6).) (*OAS; W-00-12-35622; various reviews; expected issue date: FY 2013; work in progress*)

Program Integrity—High Cumulative Part B Payments

We will review payment systems controls that identify high cumulative Medicare Part B payments to physicians and suppliers. We will determine whether payment system controls are in place to identify such payments and assess the effectiveness of those controls. Medicare Part B services must be reasonable and necessary (Social Security Act, § 1862(a)(1)(A)), be adequately documented (§ 1833(e)), and be provided consistent with Federal regulations (42 CFR, § 410). A high cumulative payment is an unusually high payment made to an individual physician or supplier, or on behalf of an individual

beneficiary, over a specified period. Prior OIG work found that unusually high Medicare payments may indicate incorrect billing or fraud and abuse. *(OAS; W-00-13-35605; various reviews; expected issue date: FY 2013; new start)*

Independent Therapists—High Utilization of Outpatient Physical Therapy Services

We will review outpatient physical therapy services provided by independent therapists to determine whether they were in compliance with Medicare reimbursement regulations. Prior OIG work found that claims for therapy services provided by independent physical therapists were not reasonable, medically necessary, or properly documented. Our focus is on independent therapists who have a high utilization rate for outpatient physical therapy services. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) Documentation requirements for therapy services are in CMS's *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 15, § 220.3. *(OAS; W-00-11-35220;W-00-12-35220; W-00-13-35220; various reviews; expected issue date: FY 2013; work in progress and new start)*

Sleep Testing—Appropriateness of Medicare Payments for Polysomnography

We will identify questionable billing patterns for Medicare sleep study services provided in 2009 and 2010. Medicare payments for polysomnography increased from $62 million in 2001 to $235 million in 2009, and coverage was also recently expanded. Sleep studies are reimbursable for patients who have symptoms such as sleep apnea, narcolepsy, or parasomnia in accordance with the CMS's *Medicare Benefit Policy Manual*, Pub. 102, ch. 15, § 70. *(OEI; 05-12-00340; expected issue date: FY 2013; work in progress)*

Sleep Disorder Clinics—High Utilization of Sleep Testing Procedures

We will review the appropriateness of Medicare payments for high utilization sleep testing procedures to determine whether they were in accordance with Medicare requirements. Our analysis of CY 2010 Medicare payments for Current Procedural Terminology (CPT) codes 95810 and 95811, which totaled approximately $415 million, showed high utilization associated with these sleep test procedures. We will examine Medicare payments to physicians, hospital outpatient departments, and independent diagnostic testing facilities for sleep testing procedures. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) Diagnostic testing that is duplicative of previous testing done by the attending physician to the extent the results are still pertinent is not covered because it is not reasonable and necessary under 1862(a)(1)(A) of the Act. Requirements for coverage of sleep tests under Part B are in CMS's *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 15, § 70. *(OAS; W-00-10-35521; W-00-12-35521; various reviews; expected issue date: FY 2013; work in progress)*

Physician-Owned Distributors— High Utilization of Orthopedic Implant Devices Used in Spinal Fusion Procedures

We will determine the extent to which physician-owned distributors (POD) provide spinal implants purchased by hospitals and are associated with high utilization of such implants. PODs are business

arrangements involving physician ownership of medical device companies and distributorships. PODs distribute orthopedic implants, such as devices used in spinal fusion procedures. However, PODs appear to be quickly growing into other areas, such as cardiac implants. Congress has expressed concern that PODs could create conflicts of interest and safety concerns for patients. *(OEI; 01-11-00660; expected issue date: FY 2013; work in progress)*

Ambulances—Compliance With Medical Necessity and Level-of-Transport Requirements

We will examine Medicare claims data to identify questionable billing for ambulance services such as transports that were potentially not medically reasonable and necessary and potentially unnecessary billing for Advanced Life Support Services and specialty care transport. We will also examine relationships between ambulance companies and other providers. Medicare pays for emergency and nonemergency ambulance services when a beneficiary's medical condition at the time of transport is such that other means of transportation are contraindicated (i.e., would endanger the beneficiary). (Social Security Act, § 1861(s)(7).) Medicare pays for different levels of ambulance service, including Basic Life Support and Advanced Life Support as well as specialty care transport. (42 CFR § 410.40(b).) *(OEI; 09-12-00351; expected issue date: FY 2012; new start; and OAS; W-00-11-35574; W-00-12-35574; various reviews; expected issue date: FY 2013; work in progress)*

Anesthesia Services —Payments for Personally Performed Services (New)

We will review Medicare Part B claims for personally performed anesthesia services to determine whether they were supported in accordance with Medicare requirements. We will also determine whether Medicare payments for anesthesiologist services reported on a claim with the "AA" service code modifier met Medicare requirements. Physicians report the appropriate anesthesia modifier to denote whether the service was personally performed or medically directed. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch.12, § 50) The service code "AA" modifier is used for anesthesia services personally performed by an anesthesiologist, and the "QK" modifier is used for medical direction of two, three, or four concurrent anesthesia procedures by an anesthesiologist. The QK modifier limits payment at 50 percent of the Medicare-allowed amount for personally performed services claimed with the AA modifier. Payments to any service provider are precluded unless the provider has furnished the information necessary to determine the amounts due. (Social Security Act, §1833(e).) *(OAS; W-00-13-35706; various reviews; expected issue date: FY 2013; new start)*

Ophthalmological Services—Questionable Billing (New)

We will review Medicare claims data to identify questionable billing for ophthalmological services during 2011. We will also review the geographic locations of providers exhibiting questionable billing for ophthalmological services in 2011. Medicare payments for Part B for physician services, which include ophthalmologists, are authorized by the Social Security Act, § 1832(a)(1), and 42 CFR § 410.20. In 2010, Medicare allowed over $6.8 billion for services provided by ophthalmologists. *(OEI; 04-12-00280; expected issue date: FY 2014; work in progress)*

Ambulatory Surgical Centers—Payment System

We will review the appropriateness of Medicare's methodology for setting ambulatory surgical center (ASC) payment rates under the revised payment system. In addition, we will determine whether a payment disparity exists between the ASC and hospital outpatient department payment rates for similar surgical procedures provided in both settings. Federal law required the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs beginning January 1, 2008. (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 626.) (See also 42 CFR § 416.171). *(OAS; W-00-10-35423; W-00-11-35423; W-00-12-35423; various reviews; expected issue date: FY 2013; work in progress)*

Ambulatory Surgical Centers and Hospital Outpatient Departments—Safety and Quality of Surgery and Procedures

We will review the safety and quality of care for Medicare beneficiaries having surgeries and procedures in ASCs and hospital outpatient departments (HOPD). We will assess care in preparation for and provided during surgeries and procedures in both settings. We will identify adverse events in both settings. CMS and stakeholders have expressed interest in the comparative safety and quality of care provided by ASCs and HOPDs. When Medicare beneficiaries require certain surgeries or procedures that do not require hospitalization, physicians generally have the option of performing such surgeries or procedures in an ASC; an HOPD; or other health care setting, such as a physician's office. Site determinations are typically made on the basis of the type of surgery or procedure, as well as the patient's health status and comorbidities. Surgeries and procedures performed in ASCs have risen substantially over the past decade. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Partial Hospitalization Programs—Services in Hospital Outpatient Departments and Community Mental Health Centers

We will review the appropriateness of Medicare payments for partial hospitalization program (PHP) psychiatric services in hospital outpatient departments and freestanding community mental health centers. We will determine whether the payments met Medicare requirements. A PHP is an intensive outpatient program of psychiatric services that hospitals may provide to individuals in lieu of inpatient psychiatric care. The program provides individuals who have mental health conditions with an individualized, coordinated, comprehensive, and multidisciplinary treatment involving nurses, psychiatrists, psychologists, and social workers. This review focuses on whether payments met Medicare requirements on the basis of documentation supporting the services, including patient plans of care and physician supervision and certification requirements. Medicare coverage of PHP services is provided by the Social Security Act, § 1832(a)(2)(J), and conditions for payment are in CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 4, § 260, and at 42 CFR §§ 410.43 and 424.24(e). *(OAS; W-00-13-35453; various reviews; expected issue date: FY 2032; new start)*

Rural Health Clinics—Compliance With Location Requirements (New)

We will determine the extent to which Rural Health Clinics (RHC) do not meet basic location requirements. The Balanced Budget Act of 1997 permitted the Centers for Medicare & Medicaid

Services (CMS) to remove clinics that do not meet location requirements from the RHC program. In 2005, OIG recommended that CMS promulgate regulations implementing the Balanced Budget Act of 1997. CMS has yet to promulgate the final regulations allowing for the removal of RHCs. As a result, RHCs that no longer meet eligibility requirements continue to receive enhanced Medicare reimbursement. We will determine the extent to which such reimbursements are occurring. *(OEI; 00-00-00000; expected issue date: FY 2014)*

Electrodiagnostic Testing—Questionable Billing (New)

We will review Medicare claims data to identify questionable billing for electrodiagnostic testing. We will also determine the extent to which Medicare utilization rates differ by provider specialty, diagnosis, and geographic area for these services. Electrodiagnostic testing, which assists in the diagnosis and treatment of nerve or muscle damage, includes the needle electromyogram and the nerve conduction test. Coverage for diagnostic testing is provided by the Social Security act, § 1861(s)(2), and 42 CFR § 410.32.) The use of electrodiagnostic testing for inappropriate financial gain poses a growing vulnerability to Medicare. *(OEI; 04-12-00420; expected issue date: FY 2013; work in progress)*

Part B Imaging Services—Payments for Practice Expenses

We will review Medicare payments for Part B imaging services to determine whether they reflect the expenses incurred and whether the utilization rates reflect industry practices. For selected imaging services, we will focus on the practice expense components, including the equipment utilization rate. Practice expenses are those such as office rent, wages, and equipment. 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 expenses. (Social Security Act, § 1848(c)(1)(B).) *(OAS; W-00-12-35219; W-00-13-35219; various reviews; expected issue date: FY 2013; work in progress and new start)*

Diagnostic Radiology—Medical Necessity of High-Cost Tests

We will review Medicare payments for high-cost diagnostic radiology tests to determine whether they were medically necessary and the extent to which the same diagnostic tests are ordered for a beneficiary by primary care physicians and physician specialists for the same treatment. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, § 1862 (a)(1)(A).) *(OAS; W-00-12-35454; W-00-13-35454; various reviews; expected issue date: FY 2013; work in progress and new start)*

Laboratory Tests—Billing Characteristics and Questionable Billing in 2010

We will describe billing characteristics for Part B clinical laboratory tests in 2010. We will also identify questionable billing for Part B clinical laboratory tests in 2010. 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. Medicare pays only for those laboratory tests that are ordered by a physician or qualified nonphysician practitioner who is

treating a beneficiary. *(42 CFR § 410.32(a). (OEI; 03-11-00730; expected issue date: FY 2013; work in progress)*

Laboratory Tests—Reasonableness of Medicare Payments Compared to Those by State Medicaid and Federal Employees Health Benefit Programs

We will determine how the methods for establishing Medicare laboratory test payment rates vary from those of State Medicaid and Federal Employees Health Benefits (FEHB) programs. Excessive payment rates for laboratory tests can be costly for Medicare. In 2009, Medicare paid nearly $10 billion for laboratory tests. We will compare Medicare laboratory payment rates for 20 laboratory tests, representing the most frequently ordered and most costly tests in terms of total dollars paid, with those of other public payers, including State Medicaid programs and FEHB plans. *(OEI; 07-11-00010; expected issue date: FY 2013; work in progress)*

Laboratory Tests—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 and determine the appropriateness of Medicare payments for these tests. Preliminary OIG work at two Medicare contractors showed variations in the contractors' procedures for screening the frequency of these tests. 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. (CMS's *Medicare National Coverage Determinations Manual*, Pub. 100-03, ch. 1, pt. 3, § 190.21.) *(OAS; W-00-12-35455; W-00-13-35455; various reviews; expected issue date: FY 2013; work in progress and new start)*

Physicians and Other Suppliers—Noncompliance With Assignment Rules and Excessive Billing of Beneficiaries

We will review the extent to which physicians and other suppliers fail to comply with assignment rules and determine to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare. We will also assess beneficiaries' awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines. Physicians participating in Medicare agree to accept payment on "assignment" for all items and services furnished to individuals enrolled in Medicare. (Social Security Act, § 1842(h)(1).) 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. *(OEI; 07-12-00570; expected issue date: FY 2014; work in progress)*

Physicians—Error Rate for Incident-To Services Performed by Nonphysicians

We will review physician billing for "incident-to" services to determine whether payment for such services had a higher error rate than that for non-incident-to services. We will also assess Medicare's ability to monitor services billed as "incident-to." Medicare Part B pays for certain services billed by physicians that are performed by nonphysicians incident to a physician office visit. A 2009 OIG review found that when Medicare allowed physicians' billings for more than 24 hours of services in a day, half of the services were not performed by a physician. We also found that unqualified nonphysicians performed 21 percent of the services that physicians did not personally perform. Incident-to services are a program vulnerability in that they do not appear in claims data and can be identified only by reviewing the medical record. They may also be vulnerable to overutilization and expose beneficiaries to care that does not meet professional standards of quality. Medicare's Part B coverage of services and supplies that are performed incident to the professional services of a physician is in the Social Security Act, § 1861(s)(2)(A). Medicare requires providers to furnish such information as may be necessary to determine the amounts due to receive payment. (Social Security Act, § 1833(e).) *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Physicians—Place-of-Service Coding Errors

We will review physicians' coding on Medicare Part B claims for services performed in ambulatory surgical centers and hospital outpatient departments to determine whether they properly coded the places of service. Federal regulations provide for different levels of payments to physicians depending on where services are performed. (42 CFR § 414.32.) 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 ambulatory surgical center. *(OAS; W-00-11-35113; various reviews; expected issue date: FY 2013; work in progress)*

Evaluation and Management Services—Potentially Inappropriate Payments in 2010

We will determine the extent to which CMS made potentially inappropriate payments for E/M services in 2010 and the consistency of E/M medical review determinations. 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. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service on the basis of the content of the service and have documentation to support the level of service reported. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 12, § 30.6.1.) *(OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress)*

Evaluation and Management Services—Use of Modifiers During the Global Surgery Period

We will review the appropriateness of the use of certain claims modifier codes during the global surgery period and determine whether Medicare payments for claims with modifiers used during such a period were in accordance with Medicare requirements. Prior OIG work found that improper use of modifiers during the global surgery period resulted in inappropriate payments. The global surgery payment

includes a surgical service and related preoperative and postoperative E/M services provided during the global surgery period. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 12, § 40.1.) Guidance for the use of modifiers for global surgeries is in CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 12, § 30. *(OAS; W-00-13-35607; various reviews; expected issue date: FY 2013; new start)*

Chiropractors—Part B Payments for Noncovered Services

We will review Medicare Part B payments for chiropractic services to determine whether such payments were in accordance with Medicare requirements. Prior OIG work identified inappropriate payments for chiropractic services furnished during calendar year (CY) 2006. Medicare-covered chiropractic services include only treatment by means of manual manipulation of the spine to correct subluxations. (42 CFR § 440.60.) Chiropractic maintenance therapy is not considered to be medically reasonable or necessary and is therefore not payable. (CMS's *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 15, § 30.5B.) Medicare will not pay for items or services that are "not reasonable and necessary." (Social Security Act, § 1862(a)(1)(A).) *(OAS; W-00-12-35606; W-00-13-35606; various reviews; expected issue date: FY 2013; work in progress and new start)*

Organ Procurement Organizations—Compliance With Supporting Documentation and Reporting Requirements

We will review Medicare payments to organ procurement organizations (OPO) to determine whether payments were correct and were supported by documentation, including whether OPOs correctly reported organ statistics for purposes of proper allocation of costs in their cost reports. An OPO coordinates the retrieval, preservation, and transportation of organs for transplant and maintains a system to allocate available organs to prospective recipients. Medicare generally reimburses OPOs under 42 CFR § 413.200 in accordance with a cost-basis method set forth at 42 CFR § 413. *(OAS; W-00-11-35568; W-00-12-35568; various reviews; expected issue date: FY 2013; work in progress)*

Claims Processing Errors—Medicare Payments for Part B Claims With G Modifiers (New)

We will determine the extent to which Medicare improperly paid claims from 2002 to 2011 in which providers entered GA, GX, GY, or GZ service code modifiers, indicating that Medicare denial was expected. Providers may use GA or GZ modifiers on claims they expect Medicare to deny as not reasonable and necessary pursuant to CMS's *Claims Processing Manual*. They may use GX or GY modifiers for items or services that are statutorily excluded. A recent OIG review 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. *(OEI; 02-10-00160; expected issue date: FY 2013; work in progress)*

End Stage Renal Disease—Medicare's Oversight of Dialysis Facilities

We will assess Medicare's oversight of facilities that provide outpatient maintenance dialysis services to Medicare beneficiaries with end stage renal disease (ESRD. We will assess the performance of oversight functions as well as the complaint processes of dialysis facilities. Dialysis facilities must meet specific

conditions to participate in Medicare. (Social Security Act, § 1881(b)(1), and 42 CFR Part 494.) CMS monitors the quality of care delivered to dialysis patients. (Balanced Budget Act of 1997 (BBA), § 4558(b).) CMS contracts with State survey and certification agencies and ESRD Networks to conduct onsite inspections of dialysis facilities and initiate corrective actions. State agencies and ESRD Networks also respond to and resolve complaints and adverse events, and utilize data for dialysis facility oversight. *(OEI; 01-11-00550; expected issue date: FY 2013; work in progress)*

End Stage Renal Disease—Bundled Prospective Payment System for Renal Dialysis Services

We will review Medicare pricing and utilization related to renal dialysis services under the new bundled ESRD PPS for renal dialysis services. We will also determine whether Medicare payments under the new ESRD PPS were made in accordance with Medicare requirements. CMS was to establish a case-mix adjusted bundled PPS for renal dialysis services beginning January 1, 2011. (Social Security Act, § 1881(b)(14).) The ESRD PPS, to be phased in over 4 years, will replace the basic case-mix adjusted composite payment system and the methodologies for reimbursement of separately billable outpatient ESRD services and will combine the payments for composite rate and separately billable services into a single payment. *(OAS; W-00-12-35608; W-00-13-35608; various reviews; expected issue date: FY 2013; work in progress and new start)*

End Stage Renal Disease—Payments for ESRD Drugs Under the Bundled Rate System

We will review payments for ESRD drugs under the new bundled rate system. We will compare facilities' acquisition costs for certain drugs to inflation-adjusted cost estimates and determine how costs for the drugs have changed since our last review. Effective January 1, 2011, Federal law required CMS to begin implementation of a new system that bundles all costs related to ESRD care (including drugs that were previously separately billable) into a single per-treatment payment. (Social Security Act, § 1881(b)(14)(A)(i).) The bundled rate must be updated annually to reflect changes in the price of goods and services used in ESRD care. CMS has based price updates on wage and price proxy data from the Bureau of Labor Statistics. (75 Fed. Reg. 49030 at page 49151 (Aug. 12, 2010).) Previous OIG work found that data from the Bureau did not accurately measure changes in facilities' acquisition costs for high-dollar ESRD drugs. *(OEI; 03-12-00550; expected issue date: FY 2013; work in progress)*

Prescription Drugs

Acronyms and Abbreviations for Selected Terms Used in This Section:

AMP—average manufacturer price
ASP—average sales price
AWP—average wholesale price
FDA—Food and Drug Administration
LCD—local coverage determination
WAMP—widely available market price

Ethics—Conflicts of Interest Involving Prescription Drug Compendia (New)

We will determine the extent to which the prescription drug compendia oversee conflicts of interest through reporting requirements and/or mitigation policies and the number and nature of the compendia's reported conflicts. Generally, Medicare covers drugs that are approved by FDA and

supported by one or more drug compendia recognized by CMS. (*Benefits Policy Manual*, Pub. 100-02, ch. 1, § 30, and ch. 15, § 50.) Recent concerns have highlighted the issue of conflicts of interest involving the drug compendia; however, CMS does not require the compendia to regularly publish conflict information, and it is unclear whether CMS conducts any oversight of the strength of the compendia's policies or the nature of their conflicts. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Patient Safety and Quality of Care—Off-Label Use of Medicare Part B Drugs

We will review off-label (prescribed for a condition that is not listed on the product's label) and off-compendia use of certain Medicare Part B prescription drugs and determine the extent to which specified compendia provide support for coverage. We will also identify CMS oversight mechanisms related to off-label use of drugs. For prescription drugs to be covered, Federal law generally requires that they be prescribed according to medically accepted indications, such as those approved by the Food and Drug Administration (FDA) or supported in one or more of the authoritative drug compendia identified by the Secretary of Health and Human Services (HHS). Therefore, most drugs are covered when used off-label as long as one of the designated compendia has determined that there is sufficient evidence that the drug is safe and effective for treating the condition. *(OEI; 03-12-00270; expected issue date: FY 2013; work in progress)*

Patient Safety and Quality of Care—Physicians' Experiences With Drug Shortages (New)

We will determine the extent to which providers of selected Part B-covered drugs in short supply report difficulty acquiring those drugs. During shortages, physicians may have to ration their supplies of certain drugs; delay treatments; use different drugs, which may be less effective; or resort to potentially untrustworthy sources to acquire drugs. In addition, we will ask providers to describe their behavior when facing a drug shortage as well as any effect on pricing, quality of care, and market availability. *(OEI; 00-00-00000; various reviews; expected issue date: FY 2014; new start)*

Patient Safety and Quality of Care—Hospitals' Experiences With Drug Shortages (New)

We will determine hospitals' reported experiences with drug shortages. During shortages, hospitals may have to ration their supplies of certain drugs; delay treatments; use different drugs, which may be less effective; or resort to potentially untrustworthy sources to acquire drugs. In addition, we will ask providers to describe their behavior when facing a drug shortage as well as any effect on pricing, quality of care, and market availability. *(OEI; 00-00-00000; various reviews; expected issue date: FY 2014; new start)*

Patient Safety and Quality of Care—Manufacturer Sales of Prescription Drugs in Short Supply (New)

We will quantify the effect of drug shortages on manufacturer sales. According to FDA, a record number of drugs were in short supply in 2010 and the number of drug shortages continued to grow in 2011. We will also use data from CMS to determine the extent to which demand and average sales prices of drugs changed when the drugs were reportedly in shortage. For any drug that did not show substantial decline in unit during the shortage quarter, we will analyze Part B claims data to determine

whether there was an increase in Part B utilization during that period. *(OEI; 00-00-00000; various reviews; expected issue date: FY 2014; new start)*

Potential Savings From Manufacturer Rebates for Part-B Drugs (New)

We will determine the potential savings associated with requiring manufacturers to pay rebates to Medicare Part B for those drugs Part B pays for on behalf of beneficiaries who are not also eligible for Medicaid (i.e., are not dual eligibles). Pursuant to the Omnibus Budget Reconciliation Act of 1990, pharmaceutical manufacturers are required to remit rebates for prescription drugs paid under Medicaid. Because of the statutorily mandated rebates, Federal and State governments were able to recoup approximately $11 billion of the $29 billion that Medicaid spent on prescription drugs in 2010. Medicare Part B spent over $16 billion on covered prescription drugs that same year. However, a comparable rebate program does not exist for Medicare Part B. *(OEI; 12-12-00260; expected issue date: FY 2013; work in progress)*

Comparison of 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) and identify drug prices that exceed a designated threshold. In 2005, Medicare began paying for most Part B drugs using a new methodology based on the ASP. Federal law requires OIG to 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. (Social Security Act, § 1847A(d).) *(OEI; 00-00-00000; various studies; expected issue date: FY 2013; new start)*

Comparison of Average Sales Prices to Widely Available Market Prices

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 to identify a designated payment-related threshold. In 2005, Medicare began paying for most Part B drugs using a new methodology based on the ASP. Federal law requires OIG to conduct studies that compare ASPs to WAMPs for Part B-covered drugs. (Social Security Act, § 1847A(d).) If OIG finds that the ASP of a drug exceeds the WAMP by a certain threshold (now 5 percent), Medicare is to base payment for the drug on the lesser of the WAMP or 103 percent of the AMP. *(OEI; 00-00-00000; various studies; expected issue date: FY 2013; new start)*

Payments for Immunosuppressive Drug Claims With KX Modifiers (New)

We will determine whether Medicare Part B payments for immunosuppressive drugs billed with a certain claims service code modifier ("KX" modifier) met Medicare documentation requirements. Medicare Part B covers FDA-approved immunosuppressive drugs and drugs used in immunosuppressive therapy when a beneficiary receives an organ transplant for which immunosuppressive therapy is appropriate. (Social Security Act, § 1861(s).) Entities that bill for immunosuppressive drugs are required to submit claims to a designated Medicare payment contractor. On or after July 2008, suppliers that furnish an immunosuppressive drug to a Medicare beneficiary annotate the claim with the KX modifier to signify that the supplier retains documentation of the beneficiary's transplant date and that such transplant

date preceded the date of service for furnishing the drug. (*Medicare Claims Processing Manual*, Pub. 100-04, ch. 17, § 80.3) *(OAS; W-00-13-35707; various reviews; expected issue date: FY 2013; new start)*

Payments for Multiuse Vials of the Drug Herceptin

We will review claims to Medicare for the drug Herceptin, which is used to treat breast cancer, to determine whether they were properly billed. For drug claims involving a single-use vial or package, if a provider must discard the remainder of a single-use vial or package after administering a dose/quantity of the drug or biological, Medicare provides payment for the amount discarded along with the amount administered, up to the amount of the drug or biological as indicated on the vial or package label. However, multiuse vials, such as those used for supplying Herceptin, are not subject to the rule for payment for discarded amounts of a drug or biological (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 17, § 40). Providers must bill accurately and completely for services provided. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 1, §§ 70.2.3.1 and 80.3.2.2.) *(OAS; W-00-11-35325; W-00-12-35325; various reviews; expected issue date: FY 2013; work in progress)*

Payments for Outpatient Drugs and Administration of the Drugs

We will review Medicare outpatient payments to providers for certain drugs and the administration of the drugs (e.g., chemotherapy drugs) to determine whether Medicare overpaid providers because of incorrect coding or overbilling of units. Prior OIG reviews have identified certain drugs, particularly chemotherapy drugs, as vulnerable to incorrect coding. Providers must bill accurately and completely for services provided. (CMS's *Medicare Claims Processing Manual*, Pub. 100-04, ch. 1, §§ 70.2.3.1 and 80.3.2.2.) Further, providers must report units of service as the number of times that a service or procedure was performed (ch. 5, § 20.2, and ch. 26, § 10.4.). *(OAS; W-00-12-35576; various reviews; expected issue date: FY 2013; work in progress)*

Payments for Physician-Administered Drugs and Biologicals

We will compare Medicare and Medicaid payments for commonly used physician-administered drugs and biologicals to determine whether changes in the reimbursement methodologies for the Part B drug program would result in significant savings. Medicare Part B covers drugs and biologicals that are usually administered by nonphysicians during a visit to a physician's office. Medicare Part B pays for most covered drugs and biologicals on the basis of the reimbursement methodology of ASP plus 6 percent. (Social Security Act, § 1847A.) Medicaid also covers physician-administered drugs and biologicals. However, under Medicaid, States have flexibility in determining reimbursement for covered drugs and biologicals as long as the ingredient cost approximates an estimated acquisition cost. In addition, manufacturers must provide rebates for Medicaid-covered drugs. (Social Security Act, § 1927(a)(1).) *(OEI; 00-00-00000; expected issue date: FY 2013; new start)*

Payments for Drugs Infused Through Medical Equipment Compared to Provider Acquisition Costs (New)

We will review provider acquisition costs for Part B-covered drugs infused through medical equipment. We will also determine the amount Medicare could have saved had payment amounts for these drugs

been based on ASP. Unlike most drugs covered under Medicare Part B, drugs infused through medical equipment are paid based on average wholesale prices (AWP). (42 CFR § 414.904(e).) Prior OIG reports found that the AWPs for Part B-covered drugs often greatly exceeded the drugs' actual costs. *(OEI; 12-12-00310; expected issue date: FY 2013; work in progress)*

Payments for Prostate Cancer Drugs Under Current Policy (New)

We will determine the financial impact of rescinding least costly alternative policies (LCA) for certain prostate cancer drugs covered under Medicare Part B. We will also determine how Medicare Part B utilization for those drugs changed after the LCA policies were rescinded. Between 1995 and 2010, certain prostate cancer drugs covered under Medicare Part B were subject to LCA policies, which based the payment amount for a group of clinically comparable products on that of the least costly one. However, in April 2010, LCA policies for Part B drugs were discontinued in response to a court ruling that found that the use of an LCA policy for certain prescription drugs was not authorized under Medicare law. *(OEI; 12-12-00210; expected issue date: FY 2013; work in progress)*

Part A and Part B Contractors

Acronyms and Abbreviations for Selected Terms Used in This Section:

CERT— Comprehensive Error Rate Testing [program]
FAR—Federal Acquisition Regulation
FI—fiscal intermediary
LCD—local coverage determination
MAC—Medicare Administrative Contractor
NSC—National Supplier Clearinghouse
RAC—Recovery Audit Contractor
ZPIC—Zone Program Integrity Contractor

Overview of CMS's Contracting Landscape (New)

This review will provide an overview of the contracting landscape at CMS. CMS relies extensively on contractors to help it carry out its basic mission, including administration, management, and oversight of its health programs. In fiscal year 2009, CMS awarded $4 billion in contracts. Recent Government Accountability Office (GAO) reports have found pervasive deficiencies in CMS's contract management internal control. Given the number of contracts and the obligated dollars for which CMS is responsible, oversight and monitoring are vital for ensuring effective programs and safeguarding taxpayer dollars. This review will determine the number, types, and dollar amount of active CMS contracts and examine how CMS maintains all of its contract information. *(OEI; 03-12-00680; expected issue date: FY 2013; work in progress)*

CMS's Compliance With Contract Documentation Requirements (New)

We will determine the extent to which CMS complies with contract documentation requirements. CMS relies on contractors to perform many of its program functions. Prior work by the Office of Inspector General has consistently identified vulnerabilities in CMS's oversight of its contractors, and reports by the Government Accountability Office have specifically identified contract file documentation as an area of concern. The Federal Acquisition Regulation (FAR) and HHS Regulations establish rules and standards for awarding and administering Government contracts, including requirements for contract file

documentation. We will also determine how CMS ensures that contract file documentation is maintained as required by regulation. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Preaward Reviews of Contractor Cost Proposals

We will review the cost proposals of various bidders for Medicare contracts. The reports produced by these reviews assist CMS in negotiating favorable and cost-beneficial contract awards. Criteria are in Office of Management and Budget (OMB) Circular A-122, *Cost Principles for Non-Profit Organizations*. *(OAS; W-00-13-35002; various reviews; expected issue date: FY 2013; new start)*

Administrative Costs Claimed by Medicare Contractors

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. We will coordinate with CMS the selection of the contractors we will review. Criteria include Appendix B of the Medicare contract with CMS and the Federal Acquisition Regulation (FAR) at 48 CFR pt. 31. *(OAS; W-00-10-35005; W-00-11-35005; W-00-12-35005; W-00-13-35005; various reviews; expected issue date: FY 2013; work in progress and new start)*

Contractor Pension Cost Requirements

We will determine whether Medicare contractors have calculated and claimed reimbursement for Medicare's share of various employee pension costs in accordance with their Medicare contracts and applicable Federal requirements. We will determine whether contractors have fully implemented contract clauses requiring them to determine and separately account for the employee pension assets and liabilities allocable to their contracts with Medicare. We will also review Medicare carriers and fiscal intermediaries whose Medicare contracts have been terminated. We will assess Medicare's share of future pension costs as well as determine the amount of excess pension assets as of the closing dates. Applicable requirements are found in the FAR at 48 CFR Subpart 31.2; Cost Accounting Standards (CAS) 412 and 413; and the Medicare contract, Appendix B, § XVI. *(OAS; W-00-12-35067; W-00-13-35067; W-00-13-35094; W-00-13-35148; various reviews; expected issue date: FY 2013; work in progress and new start)*

Contractor 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. Criteria are in the FAR at 48 CFR §§ 31.201 through 31.205. *(OAS; W-00-12-35095; various reviews; expected issue date: FY 2013; work in progress)*

Contractor Error Rate Reduction Plans

We will determine the extent to which Medicare contractors meet error rate reduction plan requirements. We will also assess CMS's oversight of the process and determine the extent to which it affects overall contractor evaluation. Each Medicare payment contractor must develop and submit an

error rate reduction plan 30 days after receipt of its annual Comprehensive Error Rate Testing program (CERT) results. Error rate reduction plans describe the corrective actions that contractors plan to take to lower the CERT paid-claims error rate and provider-compliance error rate in their jurisdictions. *(OEI; 09-12-00090; expected issue date: FY 2013; work in progress)*

Medicare Administrative Contractors—CMS's Assessment and Monitoring of Performance (New)

We will determine the extent to which CMS conducted performance assessment and monitoring of MACs. We will also describe the extent to which MACs met, did not meet, or exceeded performance standards and determine the extent to which CMS identified and MACs addressed performance deficiencies. Federal law requires the Secretary to administer Medicare Part A and Part B through contracts with MACs and to develop specific performance requirements and standards for measuring the extent to which MACs meet them. (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 911.) Previous OIG and GAO work has identified vulnerabilities in CMS's oversight of its contractors. This evaluation will build upon this body of work. *(OEI; 03-11-00740; expected issue date: FY 2013; work in progress)*

Medicare Administrative Contractors—Use and Management of System of Edits (New)

We will determine whether MACs fulfilled their contractual obligations specific to system edits in 2010 and 2011. We will also describe how MAC error rates varied across regions compared to differences in MACs' implementation, application, and evaluation of edits in 2010 and 2011. MACs are responsible for consolidating all Part A and Part B edits within their jurisdiction, as well as developing and testing final edits; implementing and using initial, local system, and medical review edits; and evaluating edit effectiveness. Since these automated edits are one of the only safeguards for identifying improper payments before Medicare payment is made, it is important that MACs properly implement and use edits. *(OEI; 04-12-00140; expected issue date: FY 2014; work in progress)*

Claims Processing Contractors—Failure To Conduct Prepayment Reviews in Response to Edits (New)

We will determine the number of Part B claims that were suspended for manual prepayment review on the basis of system edits but on which the reviews were not conducted. Because manual review is more timely and costly to the contractor, some suspended claims might not receive the review and, therefore, may be paid inappropriately. When a medical review edit reveals a billing error or claim anomaly, Medicare claims processing contractors (MACs, carriers, and intermediaries) may conduct manual prepayment or postpayment reviews. (CMS's *Program Integrity Manual*, Pub. 100-08, ch. 3.) They may also request additional medical documentation from the provider/supplier or contact beneficiaries to verify that the services actually were provided. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Recovery Audit Contractors—Identification and Recoupment of Improper and Potentially Fraudulent Payments and CMS's Oversight and Response

We will review the extent that Recovery Audit Contractors (RAC) identified improper payments, identified vulnerabilities, and made potential fraud referrals in 2010 and 2011. We will also review the activities that CMS performed to resolve RAC-identified vulnerabilities, address potential fraud referrals, and evaluate RAC performance in 2010 and 2011. On completion of a 3-year demonstration project, Congress mandated nationwide implementation of a permanent RAC program for Medicare Part A and Part B. (Tax Relief and Health Care Act of 2006 (TRHCA), § 302.) Subsequently, Congress expanded the RAC program, giving it additional responsibilities to address improper payments in Medicare (including Part C and Part D) and Medicaid. (Affordable Care Act, § 6411.) *(OEI; 04-11-00680; expected issue date: FY 2013; work in progress; Affordable Care Act)*

Zone Program Integrity Contractors—CMS's Oversight of Task Order Requirements (New)

We will review CMS oversight of fraud and abuse task order requirements for Zone Program Integrity Contractors (ZPICs). Pursuant to the FAR, CMS is required to evaluate contracts issued under the Medicare Integrity Program. Prior OIG work on benefit integritycontractor evaluations found that evaluations contained little information about performance results related to the detection and deterrence of fraud and abuse. This review will build upon prior work by reviewing the methods used to evaluate ZPIC task orders and determining the extent to which these methods focus on fraud and abuse. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

National Supplier Clearinghouse—Performance and CMS Oversight

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 their results . We will also assess CMS's oversight of the NSC. CMS, through its contract with the NSC, verifies medical equipment suppliers' initial and continuing compliance with conditions for payment. Federal regulations require medical equipment suppliers to comply with the conditions for payment, which include, among other things, requirements relating to provider enrollment. (42 CFR pt. 424, subpart P, and 42 CFR § 424.57.) OIG work in 2007 and 2008 found that fraudulent suppliers continue to enroll and participate in Medicare. *(OEI; 00-00-00000; expected issue date: FY 2014; new start)*

Contractor Information Systems Security Programs— Annual Report to Congress

We will review independent evaluations of information systems security programs of Medicare FIs, carriers, and MACs. We will report to Congress on our assessment of the scope and sufficiency of the independent evaluations and summarize their results . Federal law requires independent evaluations of the security programs of FIs, carriers, and MACs and requires OIG to assess such evaluations and report the results of its assessments to Congress. (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 912.) *(OAS; W-00-13-41010; expected issue date: FY 2013; new start)*

Contractor Closeout—Disposition of Government Systems and Data

We will review CMS's policies, instructions, and procedures designed to ensure adherence to Federal data privacy, information security, and contractual requirements and conduct information technology closeout audits at Medicare contractors that left the program during FYs 2007 and 2008. We will assess compliance with applicable Federal requirements. Our experience with previous workload transitions suggests that problems could arise with the disposition of Government systems and data when contractors leave Medicare. For example, the contractors' access rights to Medicare shared systems, the Common Working File (CWF) system, and Medicare banking records need to be terminated as soon as the contractors' performance periods end. Federal law required the Secretary to submit to Congress a plan outlining a strategy for accomplishing the replacement of FIs and carriers with MACs no later than 2011. (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), § 911.) The plan the Secretary submitted to Congress called for the establishment of 23 new administrative contracts. It also includes steps to consolidate the number of contracted data centers from 16 to no more than 4. Consequently, over the next several years, a number of contractors will leave the program. *(OAS; W-00-13-41011; various reviews; expected issue date: FY 2013; new start)*

Medicare and Medicaid Security of Portable Devices Containing Personal Health Information at Contractors and Hospitals

We will review security controls implemented by Medicare and Medicaid contractors as well as hospitals to prevent the loss of protected health information (PHI) stored on portable devices and media, such as laptops, jump drives, backup tapes, and equipment considered for disposal. Recent breaches related to Federal computers, including one involving a CMS contractor, have heightened concerns about protecting sensitive information. We will assess and test contractors' and hospitals' policies and procedures for electronic health information protections, access, storage, and transport. OMB recommended that all Federal departments and agencies take action to protect sensitive information by following the National Institute of Standards and Technology's Special Publications 800-53 and 800-53A. (OMB Memorandum M-06-16, issued June 23, 2006.) *(OAS; W-00-12-41014; various reviews; expected issue date: FY 2013; work in progress)*

Local Coverage Determinations—Impact on Physician Fee Schedule, Services, and Expenditures

We will determine to what extent Part B services and items paid under the Medicare Physician Fee Schedule are affected by Local Coverage Determinations (LCD) and the variation in coverage of these services and items as a result. We will also assess CMS's efforts to evaluate and adopt new LCDs for national coverage as required by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Medicare delegates the establishment of LCDs to third-party contractors. 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. (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA) § 521 and Social Security Act, § 1862(a)(1)(A).) 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. *(OEI; 01-11-00500; expected issue date: FY 2013; work in progress)*

Other Part A and Part B Management and Systems Issues

Acronyms and Abbreviations for Selected Terms Used in This Section:

CERT— Comprehensive Error Rate Testing (program)
NPI—national provider identifier
PECOS—Provider Enrollment, Chain, and Ownership System
PSC—Program Safeguard Contractor

Medicare as Secondary Payer—Improper Medicare Payments for Beneficiaries With Other Insurance Coverage

We will identify improper Medicare payments made for services to beneficiaries who have certain types of other insurance coverage to assess the effectiveness of Medicare's controls to prevent such payments. (Social Security Act, § 1862(b).) We will determine whether selected non-Medicare health plans properly reported insurance coverage information to Medicare as required. (Medicare, Medicaid and SCHIP Extension Act of 2007, §111). *(OAS; W-00-13-35317; various reviews; expected issue date: FY 2013; new start)*

Payments for Incarcerated Beneficiaries (New)

We will determine whether Medicare payments for incarcerated beneficiaries complied with Federal requirements. Medicare, in general, does not pay for services rendered to incarcerated beneficiaries; however, the regulation does permit Medicare payment where an incarcerated beneficiary has an obligation for the cost of care. (Social Security Act, § 1862, and 42 CFR § 411.4.) The Common Working File will reject claims on which the dates of incarceration (as obtained from the Social Security Administration) and the dates of service on the claim overlap. (CMS's *Medicare Claims Processing Manual*, ch 1, § 10.4.) In addition, the *Medicare Claims Processing Manual* provides instructions for providers who render services to incarcerated beneficiaries who meet the criteria for exception. Our review will determine whether Medicare payments were made for incarcerated beneficiaries who did not meet the criteria for exception identified in the regulations. *(OAS; W-00-12-35624; various reviews; expected issue date: FY 2013; work in progress)*

Payments for Alien Beneficiaries Unlawfully Present in the United States on the Dates of Service (New)

We will determine whether Medicare payments were made on behalf of beneficiaries who were unlawfully present in the United States on the dates of services. Medicare payment may not be made for items and services furnished to alien beneficiaries who were not lawfully present in the United States. (CMS's *Medicare Claims Processing Manual*, ch 1, § 10.1.4.8.) Medicare prohibits payment for services rendered to individuals who are not "qualified aliens." (Personal Responsibility and Work Opportunity Reconciliation Act of 1996, § 401.) CMS relies on an auxiliary file based on enrollment data

maintained by the Social Security Administration to identify claims associated with alien beneficiaries. (BBA, § 5561.) *(OAS; W-00-12-35625; various reviews; expected issue date: FY 2013; work in progress)*

Payments for Services After Beneficiaries' Death (New)

We will review Medicare claims dates to determine whether Medicare payments were made for deceased beneficiaries in 2011. We will also identify trends of Medicare claims with service dates after beneficiaries' dates of death. According to a prior OIG report, Medicare paid $20.6 million in 1997 for Part A and Part B services that purportedly started after beneficiaries' dates of death. *(OEI; 04-12-00170; expected issue date: FY 2013; work in progress)*

Undelivered Medicare Summary Notices (New)

We will review the procedures that CMS and claims processors have for handling undelivered Medicare Summary Notices (MSN). It is important that beneficiaries review their MSNs to ensure that there are no errors and that all items and services listed on the MSNs were actually received. CMS urges beneficiaries to review their MSNs to help protect Medicare and themselves from fraud; however, if beneficiaries do not receive their MSNs, they are unable to review them and report errors. *(OEI; 03-12-00600; expected issue date: FY 2014; work in progress)*

Medicare Integrity Program—CMS's Overall Strategy (New)

We will review CMS's overall strategy to maintain the integrity of the Medicare. The Medicare Integrity Program (MIP) was established through 42 U.S.C. § 1395ddd and requires CMS to contract with entities to carry out various program integrity activities to safeguard against fraud, waste, and abuse in Medicare Parts A and B. Over the past few years, Congress has submitted multiple letters to CMS questioning the effectiveness of the program integrity efforts of these contractors. We will also determine how CMS allocates funds for MIP activities and review the measures CMS uses to evaluate the performance and overall effectiveness of the MIP. *(OEI-03-12-00690; expected issue date: FY 2013 work in progress)*

Comprehensive Error Rate Testing Program—Fiscal Year 2012 Error Rate Oversight

We will review certain aspects of the CERT Program to evaluate CMS's efforts to ensure the accuracy of the FY 2012 error rate and to reduce improper payments. Through CERT, national, contractor-specific, and service-type error rates are computed. The CERT program's national estimated improper payments for FY 2011 were $28.8 billion (8.6 percent-error rate). In November 2003, CMS assumed responsibility for estimating and reporting improper Medicare FFS payments and national error rates. The CERT Program was established by CMS to meet the requirements of the Improper Payments Elimination and Recovery Improvement Act of 2011 (IPERA) and to monitor the accuracy with which Medicare claims are billed and paid. (CMS's *Medicare Program Integrity Manual,* Pub. 100-08, ch. 12.) Effective August 1, 2008, the CERT program also samples inpatient records, replacing the Hospital Payment Monitoring Program. *(OAS; W-00-13-40048; various reviews; expected issue date: FY 2013; new start)*

National Provider Identifier 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 and assess CMS's supporting processes. Federal law requires the Secretary of HHS to establish a standard unique identifier for each health care provider, health care organization, and health plan for use in the health care system. (Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Secretary established the NPI to address this requirement. Separately, Federal regulations require providers to enroll to receive payment from Medicare. (42 CFR § 424.505.) PECOS is the system CMS uses to complete the enrollments online. *(OEI; 07-09-00440; expected issue date: FY 2013; work in progress)*

CMS Disclosure of Personally Identifiable Information

We will determine whether CMS's disclosures of individuals' records are in accordance with the Privacy Act of 1974 (Privacy Act). We will also determine whether CMS is accounting for the disclosures in accordance with the Privacy Act and describe CMS's policies and practices for implementing safeguards that protect individuals' records. A "record" means any item, collection, or grouping of information about an individual maintained by an agency, including, but not limited to, financial transactions and medical history, which contains a name or identifying information. The Privacy Act allows limited disclosure of individuals' records for routine uses necessary to accomplish an agency activity. The law's requirements include keeping an accurate accounting of the name or agency to which the records were disclosed and the date, nature, and purpose of each disclosure. (Privacy Act, 5 U.S.C. § 552a(c).) *(OEI; 09-11-00430; expected issue date: FY 2013; work in progress)*

CMS Oversight of 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 medical equipment supplier debt deemed CNC was $402 million. A prior OIG review found that overpayments referred for collection by program safeguard contractors (PSC) in 2007 did not result in substantial recoveries to Medicare. *(OEI; 03-11-00670; expected issue date: FY 2013; work in progress)*

Grant Management —Stabilization Grant in the Greater New Orleans Area (New)

HHS has played a central role in post-Katrina recovery efforts, including the funding of provider stabilization grants pursuant to the Deficit Reduction Act of 2005 (DRA), § 6201(a)(4). One such grant, the Primary Care Access Stabilization Grant, was awarded by CMS to the Louisiana Department of Health and Hospitals for public and not-for-profit clinics that provide primary care to low-income and uninsured residents in the Greater New Orleans area. We will determine whether the Federal grant requirements were met. *(OAS; W-00-12-35203; various reviews; expected issue date: FY 2013; work in progress)*

First Level of the Medicare Appeals Process

We will describe redeterminations (the first level of Medicare appeals) processed in 2008-2011 for Medicare Parts A and B. A Medicare contractor has 60 days to conclude a redetermination regarding a denied claim. We will also assess the processing of redeterminations by Medicare contractors and CMS's monitoring of redeterminations processing. (Social Security Act, § 1869(a)(3)(C)(ii).)
(OEI; 01-12-00150; expected issue date: FY 2013; work in progress)

The *Work Plan* is one of OIG's three core publications. The *Semiannual Report to Congress* summarizes OIG's most significant findings, recommendations, investigative outcomes, and outreach activities in 6-month increments. The annual *Compendium of Unimplemented Recommendations* (Compendium) describes open recommendations from prior periods that when implemented, will save tax dollars and improve programs.

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