

Trends in Medicare Hospice Utilization

We will review Medicare Part A hospice claims to identify trends in hospice utilization. When the hospice benefit was created in section 122 of the Tax Equity and Fiscal Responsibility Act of 1982, Medicare did not cover more than 210 days of hospice care per beneficiary. Congress changed the benefit in section 4443 of the Balanced Budget Act of 1997 implemented by CMS at 42 CFR § 418.21, to eliminate the limit on the number of days covered by Medicare. Since then, the number and types of diagnoses associated with hospice utilization have increased, and longer stays have become more common. We will examine the characteristics of hospice beneficiaries, geographical variations in utilization, and differences between for-profit and not-for-profit providers.

(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Physicians and Other Health Professionals

Place of Service Errors

We will review physician coding of place of service on Medicare Part B claims for services performed in ambulatory surgical centers (ASC) and hospital outpatient departments. Federal regulations at 42 CFR § 414.22(b)(5)(i)(B) provide for different levels of payments to physicians depending on where the services are performed. Medicare pays a physician a higher amount when a service is performed in a nonfacility setting, such as a physician's office, than it does when the service is performed in a hospital outpatient department or, with certain exceptions, in an ASC. We will determine whether physicians properly coded the places of service on claims for services provided in ASCs and hospital outpatient departments.

(OAS; W-00-08-35113; various reviews; expected issue date: FY 2009; work in progress)

Evaluation and Management Services During Global Surgery Periods

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

(OAS; W-00-07-35207; various reviews; expected issue date: FY 2009 and FY 2010; work in progress)

Medicare Practice Expenses Incurred by Selected Physician Specialties

We will review the actual expenses of selected physician specialties. Physician services include medical and surgical procedures, office visits, and medical consultations. Physicians are paid for services pursuant to the MPFS, which covers the major categories of costs including the physician professional cost component, malpractice costs, and practice expense. The Social Security Act, § 1848(c)(1)(B), defines "practice expense" as the portion of the resources used in furnishing the service that reflects the general categories of expenses, such as office rent, wages of personnel, and equipment. We will determine whether Medicare payments for physician

services performed by selected specialties are comparable to the actual expenses incurred by the physicians in providing services and operating their practices.

(OAS; W-00-09-35219; various reviews; expected issue date: FY 2009; new start)

Services Performed by Clinical Social Workers

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

(OAS; W-00-09-35405; various reviews; expected issue date: FY 2009; new start)

Outpatient Physical Therapy Services Provided by Independent Therapists

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

(OAS; W-00-09-35220; various reviews; expected issue date: FY 2009; new start)

Medicare Payments for Colonoscopy Services

We will review the appropriateness of Medicare payments to physicians for colonoscopy services. A colonoscopy is a complex procedure for examining the entire colon and may include, for example, biopsy to remove polyps, tumors, or other lesions or related services that the physician may deem necessary, such as medical consultations and office visits. A colonoscopy generally requires that the patient be placed under sedation in an outpatient hospital setting. The Social Security Act, § 1833(e), precludes payment to any service provider unless the provider has furnished the information necessary to determine the amounts due such provider. We will determine whether Medicare payments for colonoscopy services were properly supported, billed, and paid in accordance with Medicare requirements.

(OAS; W-00-09-35221; various reviews; expected issue date: FY 2009; new start)

Physicians’ Medicare Services Performed by Nonphysicians

We will review services physicians bill to Medicare but do not perform personally. Such services, called “incident to,” are typically performed by nonphysician staff members in physicians’ offices. The Social Security Act, § 18610(s)(2)(A), provides for Medicare coverage of services and supplies performed “incident to” the professional services of a physician. However, these services may be vulnerable to overutilization or put beneficiaries at risk of receiving services that do not meet professionally recognized standards of care. We will

examine the qualifications of nonphysician staff that perform “incident to” services and assess whether these qualifications are consistent with professionally recognized standards of care. (OEI; 09-06-00430; expected issue date: FY 2009; work in progress)

→ **Appropriateness of Medicare Payments for Polysomnography**

We will examine the appropriateness of Medicare payments for sleep studies. Sleep studies are reimbursable for patients with symptoms consistent with sleep apnea, narcolepsy, impotence, or parasomnia in accordance with the CMS “Medicare Benefit Policy Manual,” Pub. No. 100-02, ch. 15, § 70. Medicare payments for polysomnography increased from \$62 million in 2001 to \$215 million in 2005. We will also examine the factors contributing to the rise in Medicare payments for sleep studies and assess provider compliance with Federal program requirements. (OEI; 00-00-00000; expected issue date: FY 2010; new start)

Long-Distance Physician Claims Requiring a Face-to-Face Visit

We will review the appropriateness of Medicare claims for long-distance evaluation and management services. Pursuant to the CMS “Medicare Benefits Policy Manual,” Pub. No. 100-02, ch. 15, § 30, a service may be considered a physician’s service if the physician either examines the patient in person or is able to visualize some aspect of the patient’s condition without a third person’s judgment. Although services provided by means of a telephone call between the physician and the beneficiary may be covered under Medicare, there are certain services that require a face-to-face visit. Previous OIG work identified instances of physicians billing for services that would normally require a face-to-face examination for beneficiaries who lived a significant distance from the physician. We will also examine factors that contribute to the submission of long-distance physician claims. (OEI; 07-08-00350; expected issue date: FY 2009; work in progress)

→ **Geographic Areas With a High Density of Independent Diagnostic Testing Facilities**

We will review services and billing patterns in geographic areas with high concentrations of independent diagnostic testing facilities (IDTF). An IDTF is a facility that performs diagnostic procedures and is independent of a physician’s office or hospital. It may have a fixed location or be a mobile entity, and the practitioner performing the procedures may be a nonphysician. IDTFs must meet performance requirements at 42 CFR § 410.33 to obtain and maintain Medicare billing privileges. A 2006 OIG review found numerous problems with IDTFs, including noncompliance with Medicare standards and potential improper payments of \$71.5 million. In areas with a high density of IDTFs, we will examine service profiles, provider profiles, beneficiary profiles, and billing patterns. (OEI; 00-00-00000; expected issue date: FY 2010; new start)

Patterns Related to High Utilization of Ultrasound Services

We will review services and billing patterns in geographic areas with high utilization of ultrasound services paid under the MPFS. The Social Security Act, § 1848(a)(1), establishes the MPFS as the basis for Medicare reimbursement for all physician services, including ultrasound services, and section 1862(a)(1)(A) provides that Medicare will pay for services only if they are medically necessary. In areas of high utilization of ultrasound services, we will examine service profiles, provider profiles, and beneficiary profiles. (OEI; 01-08-00100; expected issue date: FY 2009; work in progress)

Medicare Payments for Chiropractic Services Billed With the Acute Treatment Modifier

We will review chiropractor billings with acute treatment (AT) modifiers to determine whether they comply with Medicare coverage criteria and documentation requirements. The Social Security Act, § 1861(r)(5), defines physicians as including chiropractors, but only for treatment by manual manipulation of the spine to correct subluxations of the spine. Chiropractors must use an AT modifier to identify services that are active or corrective treatment of an acute or chronic subluxation. Federal regulations at 42 CFR § 410.21(b) further limit Medicare payment to treatment of subluxations that result in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment. The Social Security Act, §§ 1862(a)(1)(A) and 1833(e), provides that Medicare pay for services only if they are medically necessary and supported by documentation. A prior OIG review of services allowed in 2001 found that 40 percent of chiropractic services were for maintenance therapy and thus did not meet Medicare coverage criteria, potentially costing the program and its beneficiaries approximately \$186 million in improper payments. We will determine the appropriateness of Medicare payments for chiropractic claims identified as maintenance therapy.

(OEI; 07-07-00390; expected issue date: FY 2009; work in progress)

Physician Reassignment of Benefits

We will review the extent to which Medicare physicians reassign their benefits to other entities. The Social Security Act, § 1842(b)(6), prohibits physicians who provide services to Medicare beneficiaries from reassigning their right to Medicare payments to other entities, unless a specific exception applies. For example, physicians are permitted to reassign benefits to other entities enrolled in Medicare when contractual arrangements that meet certain program integrity safeguards exist between the physicians and the entities or when payments are being made to the physicians' employers. Investigations in South Florida have revealed schemes in which fraudulent providers obtain identifying information about legitimate physicians and request reassignments on their behalf. We will examine a national sample of Medicare physicians to determine the extent to which they reassign their benefits to other entities and the extent to which the physicians are aware of their reassignments.

(OEI; 07-08-00180; expected issue date: FY 2009; work in progress)

Medicare Payments for Unlisted Procedure Codes

We will review the accuracy of Medicare payments for services billed using unlisted procedure codes. Unlisted procedure medical codes are miscellaneous codes used by service providers only when there are no specific Healthcare Common Procedure Coding System (HCPCS) codes that accurately identify the medical service furnished. The Social Security Act, § 1848(a)(1), establishes the MPFS, which provides a payment amount for almost all HCPCS codes, as the basis for Medicare reimbursement for physician services. However, unlisted procedure codes are not paid under the fee schedule. The Medicare contractors that process such claims suspend them for individual review and manual pricing. We will examine provider usage of procedure codes for services not listed in the HCPCS.

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Laboratory Test Unbundling by Clinical Laboratories

We will review the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments. Pursuant to the "Medicare

Durable Medical Equipment and Supplies

Durable Medical Equipment Payments for Beneficiaries Receiving Home Health Services

We will review Medicare Part B claims for DME, prosthetics, orthotics, and supplies that are furnished to beneficiaries receiving HHA services. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.” CMS’s “Medicare Benefit Policy Manual,” Pub. No. 100-02, ch. 15, § 110.1.C, provides additional guidance on the application of the medical necessity requirement for DME. Based on OIG interviews with home health patients, there were indications of unnecessary DME being ordered for beneficiaries receiving home health services. We will determine whether DME claims paid by Medicare on behalf of beneficiaries receiving home health services were allowable.

(OAS; W-00-07-35196; various reviews; expected issue date: FY 2010; work in progress)

Medicare Payments for Various Categories of Durable Medical Equipment

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

(OAS; W-00-09-35223; various reviews; expected issue date: FY 2009; new start)

Medicare Payments for Durable Medical Equipment Claims With Modifiers

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

(OAS; W-00-08-35305; various reviews; expected issue date: FY 2009; work in progress)

→ Medicare Payments for Continuous Positive Airway Pressure Devices

We will review the appropriateness of Medicare Part B payments for continuous positive airway pressure (CPAP) devices. Pursuant to the Social Security Act, § 1862(a)(1)(A), Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and

treatment of illness or injury or to improve the functioning of a malformed body member.” CMS’s “Medicare National Coverage Determinations Manual,” Pub. No. 100-03, ch. 1, pt. 4, § 240.4, states that Medicare covers CPAP devices and therapy only if beneficiaries have obstructive sleep apnea and the results of the polysomnography performed in facility-based sleep study laboratories meet certain benchmarks. Previous OIG work revealed cases in which Medicare paid for CPAP devices that were not used by or delivered to beneficiaries. We will determine whether Medicare payments for CPAP devices were supported, billed, and paid in accordance with Medicare requirements.

(OAS; W-00-09-35224; various reviews; expected issue date: FY 2009; new start)

Comprehensive Error Rate Testing Program: Fiscal Year 2009 Durable Medical Equipment Error Rate

We will review certain aspects of CMS’s CERT methodology for determining the 2008 DME error rate. The IPFA and OMB’s implementation of that Act in memorandum M-06-23 require Federal agencies to annually develop statistically valid estimates of improper payments made under programs with significant risks of erroneous payments. CMS and one of its contractors plan to review a subsample of claims from the 2008 CERT program to determine the reasonableness of the error rate and confirm that the CERT contractor followed CMS’s requirements in establishing the error rate. OIG will review the same subsample of DME claims to evaluate the adequacy and reasonableness of CMS’s DME subsample review and verify corrective actions that CMS has taken to improve the accuracy of the CERT DME error rate process.

(OAS; W-00-09-40043; expected issue date: FY 2010; new start)

Comprehensive Error Rate Testing Program: Durable Medical Equipment Corrective Actions

We will review CMS’s corrective actions in response to recommendations in OIG’s final report dated August 22, 2008 regarding the medical review of claims for the FY 2006 CERT DME review. In the report we recommended that CMS require the CERT contractor to review all available supplier documentation, review all medical records necessary to determine medical necessity, and contact beneficiaries named on high-risk claims. In response to the recommendations, CMS stated that beginning with the 2009 measurement cycle, it would implement the recommendation for reviews of claims for diabetic test strips, oxygen, and powered mobility devices. CMS also indicated that it had issued directions on the appropriate use of clinical inference; would ensure that oral guidances, policy clarifications, and technical directions are followed up with written directions to medical reviewers; and would provide Medicare providers the information they need to understand the program, be informed timely about changes, and bill correctly. We will verify actions taken by CMS to implement our recommendations.

(OAS; W-00-09-40044; expected issue date: FY 2009; new start)

Part B Services in Nursing Homes: Overview

We will review the extent of Part B services provided to nursing home residents whose stays are not paid for under Medicare’s Part A SNF benefit. Unlike services provided during a Part A SNF stay, which are billed to Medicare directly by the SNF in accordance with consolidated billing requirements, Part B services are provided and billed directly by suppliers and other providers. In repealing consolidated billing provisions that would have applied to non-Part A

Accuracy and Completeness of the National Provider Identifier

We will review the accuracy and completeness of NPIs, which are unique identification numbers for health care providers. CMS regulations at 45 CFR § 162.404 require that, beginning May 23, 2007 (May 23, 2008, for small health plans), NPIs be used in lieu of legacy provider identifiers when submitting claims. Providers failing to obtain their NPIs risk losing their ability to receive payment for services provided to Medicare and Medicaid beneficiaries. By May 23, 2008, all Medicare providers had to include their NPIs when submitting claims. We will determine whether CMS has met program goals for implementation of NPIs.

(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Recovery Audit Contractors: Reducing Medicare Improper Payments

We will review CMS's oversight and monitoring of recovery audit contractors (RAC) to determine whether they meet contractual requirements outlined in the RAC Task Orders. The RAC program, authorized in section 306 of the MMA, is designed to reduce Medicare improper payments through the detection and collection of overpayments, the identification of underpayments, and the implementation of actions that will prevent future improper payments. Section 302 in Division B of the TRHCA requires the Secretary to utilize RACs in the Medicare Integrity Program to identify underpayments and overpayments and recoup overpayments associated with services for which payments are made under Medicare Part A or Part B.

(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Medicare Contractors' Use of Payment Suspensions and Other Administrative Sanctions

We will review MACs' and Program Safeguard Contractors' use of payment suspensions and other administrative sanctions intended to prevent payments to providers and suppliers suspected of fraud. Pursuant to 42 CFR § 405.371, CMS or its contractors can suspend payments to providers or suppliers based upon the existence of reliable information of an overpayment or fraud. Payment suspensions temporarily stop payment until contractors identify and determine overpayments. We will examine CMS's oversight and contractors' implementation of payment suspensions and other administrative sanctions.

(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Collection of Medicare Overpayments Referred by Program Safeguard Contractors

We will review overpayments that program safeguard contractors referred to claims processors for collection in 2007. Section 202(a) of the HIPAA established the Medicare Integrity Program, which requires CMS to engage contractors to review Medicare claims, among other things, for possible overpayments. Pursuant to this provision, program safeguard contractors perform investigative work on Medicare payments to detect and deter fraud and abuse. When they identify overpayments that have been made to Medicare providers and beneficiaries, they refer them to Medicare claims processors for collection. We will examine the amount of overpayments that Medicare claims processors have collected as a result of overpayment referrals and identify the procedures the program safeguard contractors and claims processors use to identify and track possible fraud and abuse related to the overpayments.

(OEI; 03-08-00030; expected issue date: FY 2009; work in progress)