Nail Debridement

This ***Operation Restore Trust*** study will determine why significant variances exist for nail debridement claims among carriers, and assess how carrier policies have affected payment for such claims. Expenditures for nail debridement increased 26 percent from 1991 to 1992 (1993 data not available), to reach $167 million. Increases of 370 percent and 800 percent occurred in two carriers for one code; four carriers account for half the total expenditures for another code; and two carriers account for half of the total for a third code. We believe much of this service occurs in nursing homes.

OEI; 04-94-00440
Expected Issue Date: FY 1997

HOSPICE

Eligibility for Hospice Care

These provider-specific ***Operation Restore Trust*** reviews will determine if payments made to hospices for beneficiaries determined to be terminally ill were appropriate and in accordance with program requirements. We will also evaluate various policy options in order to assess that necessary care is rendered only to eligible beneficiaries. In order to be eligible for hospice care under Medicare, an individual must be entitled to Part A, and be certified as terminally ill with a life expectancy of 6 months or less. Previous reviews determined that some hospices were improperly certifying beneficiaries as eligible for hospice care and were receiving millions of dollars in improper payments.

OAS; W-00-95-20072; A-05-95-00052; A-05-96-00024; A-06-96-00024; A-06-96-00027; A-06-95-00095; A-09-96-00064
Expected Issue Date: FY 1997

National Hospice Deficiencies

We will summarize conditions disclosed by ***Operation Restore Trust*** reviews of 12 hospice locations in Illinois, Florida, Texas and California. Problems of ineligible recipients, reimbursement caps, sales or marketing methods, and other systemic weaknesses will be presented in a report to HCFA together with recommendations or options that would tighten program controls. As we receive information from our financial statement reviews of hospice payments, we will begin additional reviews.

OAS; W-00-96-30015; A-05-96-00023
Expected Issue Date: FY 1997

Hospice and Hospital/Skilled Nursing Facility Overpayments

This ***Operation Restore Trust*** follow-up review will update and expand a recent nationwide review which disclosed a significant number of improper payments to hospitals and skilled nursing facilities for hospice patients. The review will include an evaluation of whether controls implemented by HCFA in response to the prior review are effective in preventing overpayments.

OAS; W-00-96-30015; A-02-96-01017
Expected Issue Date: FY 1997

Part B Payments For Hospice Patients

This ***Operation Restore Trust*** review will determine the appropriateness of payments made to physicians, durable medical equipment suppliers and other providers of Part B services on behalf of hospice patients. Separate Part B payments for hospice beneficiaries are appropriate only for conditions unrelated to the patient's terminal illness. A recent nationwide review disclosed significant

problems in Part A payments to hospitals and skilled nursing facilities for hospice patients, a similar situation appears to be occurring on the Part B side.

OAS; W-00-96-30015
Expected Issue Date: FY 1997

Hospice Services Provided to Patients in Nursing Facilities

This ***Operation Restore Trust*** study will examine how payments are being made for patients in nursing facilities who are also receiving hospice benefits. Our goal will be to identify systemic vulnerabilities that might result from overlapping Medicare and Medicaid payment policies and to suggest possible solutions. We will also describe how nursing home patients are enrolled in a hospice and explore how responsibilities between the hospice and nursing home are being delineated for the management and delivery of care to these terminally ill patients.

OEI; 05-95-00250
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Hospice: Referral Sources and Patient Care

This study will examine the appropriateness of services provided to hospice patients, the payments for those services, patient selection, and patient protections as well as referral sources. Medicare provides for two 90-day periods of hospice care, and one 30-day period, with a final unlimited period for terminally ill patients certified to have a life expectancy of 6 months or less. Covered services include nursing and physician services, counseling, durable medical equipment, home health aide services, and physical therapy. Once a patient is certified, elects a hospice, and is under a plan of care, the hospice is paid a prospective per diem rate for that patient, regardless of whether any services are rendered on a given day. The hospice's total yearly payments are subject to an aggregate cap per patient. Patients can revoke their choice of

hospice once per period. Evidence from OIG reviews and other sources indicate questionable payments being made in hospice services.

OEI; 04-93-00270
Expected Issue Date: FY 1997

PHYSICIANS

Variation in Utilization of Physician Services

This review will assess the variation in the use of physician services and attempt to explore both the discretionary and nondiscretionary influences on that variation. Physician services account for a significant portion of Medicare expenditures annually. Like most services, there is a significant variation in the utilization of physician services across the country. These variations may be the result of nondiscretionary influences (health status and demographics of population) or discretionary influences (physician payment styles). As part of our analysis, we will select a few procedures or groups of services for comparison. This study will provide insights about utilization and billing practices that will enable the OIG to target categories of potentially abusive billings for further review.

OEI; 00-00-00022
Expected Issue Date: FY 1997

Clinical Practice Billings

An OIG review of a physician group practice at an East Coast university teaching hospital disclosed that the practice was improperly billing Medicare for the services of supervising physicians or were billing for services at a level not supported by medical records. An OIG/Department of Justice (DOJ) project team negotiated a $30 million settlement with the physician group practice for

were inappropriately reimbursed under the fee-for-service program. We will also determine if any additional payment amounts, such as on a passthrough basis, were inappropriately charged to the Medicare program.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

Hospice Services Furnished Enrollees

This review will examine payments made for hospice care to beneficiaries enrolled in health maintenance organizations (HMO). If an enrollee elects Medicare hospice coverage, the care may only be furnished through a Medicare certified hospice that is paid directly by Medicare. Medicare capitation payments made to the HMO are suspended on the effective date of election of Medicare hospice benefits. Medicare payments for hospice service is greater than the monthly HMO capitation payment. We have noted instances where capitation payments have been reinstated for beneficiaries after they ended their hospice care election. We will determine if these beneficiaries were improperly certified as eligible for hospice care and if HMOs have shifted high cost beneficiaries to hospice care.

OAS; W-00-97-30012
Expected Issue Date: FY 1997

MEDICAID MANAGED CARE

Targeted Case Management

We will assess States' implementation of Medicaid targeted case management. States may provide case management under Medicaid. States have targeted these services to special populations including pregnant women, chronically mentally ill, developmentally disabled, and those with HIV. Given the increasing State interest in including disabled, chronically ill populations under capitated

Medicare Part A

Medicare Part A helps pay for four kinds of medically necessary care: inpatient hospital care, inpatient care in a facility, home health care, and hospice care. Approximately 58 percent of the Medicare dollar is spent on Medicare Part A services. We will investigate facilities or entities that billed the Medicare program for services not rendered, or that manipulated payment codes in an effort to inflate their reimbursement amount. We will also investigate business arrangements that violate anti-kickback statutes.

Medicare Part B

Medicare Part B helps pay for: doctor's services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies which are not covered by Medicare Part A. The most common Medicare Part B violation involves false claims to obtain payments to which the provider is not entitled. The OIG receives complaints from a variety of sources and conducts widespread investigations into fraudulent schemes in various areas of medical service. We will investigate a broad range of suspected fraud and present cases for both criminal and civil prosecution.

Medicaid

The Medicaid program provides grants to States for medical assistance payments. The majority of States have taken advantage of available Federal funding to establish Medicaid fraud control units to investigate criminal violations. Medicaid fraud investigations by OIG will be conducted only in States without such units or where there is a shared interest. In addition to sustained scrutiny of the principal health care programs administered by HCFA, the OIG will focus attention on HCFA grants and contracts with carriers and intermediaries.