Hospice Part B Billings

We will determine the appropriateness of selected durable medical equipment Part B billings 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-00-98-30015; A-02-98-00000

Medical Necessity of Oxygen

We will compare Medicare beneficiaries' self-reported use of home oxygen therapy with documentation supporting the medical need for such therapy. We will assess the prescribing practices of physicians who order the systems and how Medicare monitors utilization and medical necessity for the systems. Allowances for oxygen equipment increased from about $835 million in 1992 to over $1.6 billion in 1995.

OEI; 03-96-00090

Orthotic Body Jackets

In this follow-up study, we will examine whether suppliers are still billing for "non-legitimate" orthotic body jackets. In 1993, the OIG issued a report on Medicare payments for orthotic body jackets and found that 95 percent of the claims submitted should not have been paid because the "body jackets" did not meet construction and medical necessity criteria. Many of the devices were primarily used to keep patients upright in wheelchairs.

OEI; 04-97-00390

Licensing Requirements for Prescription Drug Suppliers

We will determine if entities that bill for providing drugs and similar medications to Medicare beneficiaries meet required licensing requirements. Effective December 1, 1996, HCFA issued a new policy requiring these entities to have pharmacy licenses.

vulnerable program areas that can be eliminated through corrective management actions, regulation, or legislation; by pursuing criminal convictions; and by recovering the maximum dollar amounts possible through judicial and administrative processes, for recycling back to the intended beneficiaries.

While each year literally thousands of complaints from various sources are brought to the OIG's attention for development, investigation, and appropriate conclusion, OI has targeted certain high-risk areas for continued investigative concentration for as long as there appears to be a high probability that wrongdoing will be uncovered, prosecuted, and deterred in these areas. Although OIG managers will continue to make their investigative decisions on a case-by-case basis, this Work Plan identifies several investigative focus areas in which we will concentrate our resources. These focus areas will be updated and modified as necessary to clearly and accurately represent our major investigative activities.

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 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 doctors' services, outpatient hospital care, diagnostic tests, durable medical equipment, ambulance services, and many other health services and supplies not covered by Medicare Part A. The most common Part B violation involves false provider claims to obtain payments. 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.