allergen immunotherapy codes and related services in 2000. In a recent probe medical review, the reviewers found that allergen immunotherapy treatment was medically inappropriate in 12 of 18 cases. Inappropriateness was often based on the length of treatment or the presence of strong contraindications, which greatly increased the risk of adverse reaction to the treatment. In addition, the majority of the claims were either inadequately documented or medically unnecessary.

*OEI; 09-00-00531* *Expected Issue Date: FY 2004*

## OTHER MEDICARE SERVICES

### Beneficiaries' Experiences With Medigap Insurance

This study will examine beneficiary access to and experiences with Medigap insurance. Many beneficiaries purchase supplemental insurance policies, referred to as Medigap policies, to cover items and charges not covered by the Medicare program. The Federal Government regulates and sets policies on this insurance. As part of our study, we will assess the factors that influence a beneficiary's decision to purchase a Medigap policy, such as affordability and available pricing and premium information.

*OEI; 00-00-00000* *Expected Issue Date: FY 2004*

### Medicare Payments in Outpatient Settings

We will determine the extent to which payments for the same procedure codes vary between hospital outpatient departments and ambulatory surgical centers and assess the effect of this variance on the Medicare program. Our reports in the early 1990s documented that Medicare was paying higher rates in outpatient departments than in ambulatory surgical centers for the same procedure codes. The Congress subsequently made a number of payment reductions for services in outpatient departments.

*OEI; 05-00-00340* *Expected Issue Date: FY 2003*

### Hospice Payments and Plans of Care

This follow-up study will examine the financial implications of Medicare hospice payments made on behalf of beneficiaries residing in nursing facilities. Our previous work found that such payments may be excessive. When a patient is entitled to both Medicare and Medicaid, the nursing home no longer bills the state Medicaid program for the patient's long term care. Instead, the nursing home bills and receives payment from the hospice, and the hospice bills both Medicare and Medicaid. Medicaid payments are for room and board and are in addition to

Medicare's daily fixed rate paid to the hospice. For private pay patients, Medicare pays the hospice and the resident continues to pay the nursing facility directly. This study will focus on private pay patients and assess whether patients are receiving care in accordance with their plans of care.

*OEI; 05-02-00570* *Expected Issue Date: FY 2004*

## Medicare Payments for Clinical Trials

This review will determine whether Medicare payments associated with clinical trials were made in accordance with program requirements. After the President issued an executive memorandum in June 2000, Medicare began to cover the routine health care costs of beneficiaries in clinical trials. Our review will examine whether Medicare is making payments associated with noncovered aspects of clinical trials and whether Medicare billing systems have adequate controls to identify and monitor the appropriateness of these payments.

*OEI; 09-02-00360* *Expected Issue Date: FY 2003*

## Independent Diagnostic Testing Facilities

We will review the appropriateness of Medicare payments to independent diagnostic testing facilities. These facilities (formerly known as independent physiological laboratories) may be fixed-location or mobile entities that are independent of a hospital or a physician's office. Medicare covers diagnostic tests performed by such facilities when the services are medically necessary and satisfy certain criteria regarding, among other things, physician supervision and the qualifications of nonphysician personnel.

*OAS; W-00-02-35066; A-03-02-00017* *Expected Issue Date: FY 2003*

## New Payment Provisions for Ambulance Services

We will determine whether payments for ambulance services complied with new Medicare reimbursement regulations. The Balanced Budget Act of 1997 required CMS to implement a national fee schedule covering seven levels of service intensity for ground transport and two levels for air transport. The fee schedule is being phased in over the 5 years that began in April 2002. By reviewing billing and medical record documentation, we will determine whether ambulance companies billed Medicare for the appropriate level of service intensity.

*OAS; W-00-03-35076; A-01-03-00000* *Expected Issue Date: FY 2004*