Medicare Hospice

Hospice Payments to Nursing Facilities

We will determine whether hospice payments for services for dually eligible patients/residents residing in nursing facilities are accurate. OIG's previous work in this area indicated that nursing home hospice patients received nearly 46 percent fewer nursing and aide services from hospice staff than hospice patients living at home. OIG also raised concerns about the appropriateness of the arrangements hospices have with nursing facilities to provide services. We will examine what services are provided by hospice, by nursing homes, whether there are any overlaps in these services, and, if so, identify any duplication in reimbursement by Medicare hospice and Medicaid.
(OEI; 02-06-00220; expected issue date: FY 2007; work in progress)

Hospice: Plans of Care and Appropriate Payments

This review will determine if assessments were completed and if the plans of care correctly reflect the assessments for beneficiaries receiving hospice care. We will also determine whether beneficiaries are receiving services billed for and whether hospices are billing for services at the correct level of care. By conducting a medical record review, we will determine if the plans of care accurately reflect each patient assessment, and whether all patients received a plan of care documenting all required services including their location, frequency, and level of care.
(OEI; 00-00-0000; expected issue date: FY 2008; new start)

Medicare Physicians and Other Health Professionals

Billing Service Companies

We will identify and review the relationships between billing companies and the physicians and other Medicare providers who use their services. We will identify the types of arrangements that physicians and other Medicare providers have with billing services and determine the impact of these arrangements on physicians' billings.
(OAS; W-00-05-35162; various reviews; expected issue date: FY 2007; work in progress)

Physician Pathology Services

We will determine whether the billings for pathology laboratory services comply with Medicare Part B requirements. We will focus on pathology services performed in physicians' offices. Medicare pays more than $1 billion annually to physicians for pathology services. We will also identify and review the relationships between physicians who furnish pathology services in their offices and outside pathology companies.
(OAS; W-00-05-35164; various reviews; expected issue date: FY 2007; work in progress)

Cardiography and Echocardiography Services

We will review Medicare payments for cardiography and echocardiography services to determine whether physicians billed appropriately for the professional and the technical components of the services. Like many physician services, cardiography and echocardiography include both technical and professional components. When a physician performs the interpretation separately, the modifier 26 should be used to bill Medicare.
(OAS; W-00-06-35165; various reviews; expected issue date: FY 2007; work in progress)

Medicare Part D: Drug Access Through Prior Authorization and Exceptions

We will examine controls that CMS has instituted to ensure that Medicare Part D prescription drug plans (PDP) implement appropriate prior authorization and formulary exceptions processes. The study will also explore how policies and processes compare across PDPs.
(OEI; 06-06-00340; expected issue date: FY 2007; work in progress)

Monitoring Drug Prices of Medicare Part D Drug Plans

We will examine changes and trends in Medicare Part D prescription drug prices. We will explore to what extent drug plans' prices fluctuated over time to include price variations during the open enrollment period compared to patterns after enrollment closed. We will also assess whether plans show consistent pricing trends and patterns and how trends compare across drug plans.
(OEI; 03-06-00520; expected issue date: FY 2007; work in progress)

Part D Dual-Eligible Demonstration Project

We will review CMS's system to reimburse States participating in the Part D Dual-Eligible Demonstration Project. As part of the transition of beneficiaries into the Part D program, CMS has initiated a demonstration project to reimburse States for their efforts in assisting their dual eligible and low-income subsidy entitled populations in obtaining Medicare Part D coverage and paying for prescriptions for beneficiaries lacking coverage. Medicare will reimburse States for the difference between the drug plan reimbursement and Medicaid costs, as well as certain State administrative costs. We will also review the States' submission of data to determine accuracy of payments.
(OAS; W-00-06-31122; A-03-06-00203; expected issue date: FY 2007; work in progress)

Dually Eligible Hospice Patients

We will determine the propriety of drug claims for individuals that are receiving hospice benefits under Medicare Part A and drug coverage under Medicare Part D. CMS established daily per diem rates to pay for hospice benefits, which include prescription drugs (used for pain relief and symptom control) related to the beneficiary's terminal illness. Hospice providers are paid daily per diem amounts, which include drugs related to a hospice beneficiary's terminal illness. Medicare Part D, which began January 2006, covers prescription drugs for Medicare beneficiaries enrolled in this voluntary benefit. Because the hospice program continues to cover prescription drugs related to a hospice beneficiary's terminal illness, Medicare Part D drug plans may unknowingly duplicate payments for prescription drugs related to a hospice beneficiary's terminal illness. We will identify whether this is a widespread problem and, if so, the controls needed to prevent duplicate drug payments.
(OAS; W-00-07-35307; various reviews; expected issue date: FY 2007; new start)

Medicare Part D Duplicate Claims

We will review CMS's controls to prevent duplicate Part D claims for the same beneficiary, particularly when a beneficiary changes plans, tries to enroll in more than one plan, or tries to enroll in a plan and a retiree-subsidy covered plan. As of January 2006, there were more than 6 million beneficiaries dually eligible for Medicare and Medicaid assigned to a Part D plan. These beneficiaries are allowed to change their enrollment in a prescription drug plan monthly.
(OAS; W-00-07-35308; various reviews; expected issue date: FY 2007; new start)