rates applied under a PPS to SNFs effective July 1, 1998. Medicare pays for Part A-covered SNF stays based upon a PPS that includes a case-mix adjustment based upon groups, referred to as RUGs. A 2006 OIG report found that 22 percent of claims were upcoded, representing $542 million in potential overpayments for FY 2002. As part of our follow-up work, we will also identify areas to improve the accuracy of payments to SNFs.
(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Medicare Hospice Care

Medicare Hospice Care for Nursing Home Residents: Services and Appropriate Payments

We will review the nature and extent of hospice services that are provided to Medicare beneficiaries who reside in nursing facilities and assess the appropriateness of payments for hospice care for these services. Section 1861(dd) of the Social Security Act governs hospice care in the Medicare program. Medicare hospice spending doubled from $3.5 billion to $7 billion from 2001 to 2004, with the growth associated mostly with nursing home residents. A previous OIG review found that hospice beneficiaries in nursing facilities received nearly 46 percent fewer nursing and aid services than hospice beneficiaries residing at home. By conducting a medical record review of selected beneficiaries, we will assess beneficiaries' plans of care and determine whether the services they receive are consistent with their plans of care and whether payments are appropriate.
(OEI; 02-06-00221; expected issue date: FY 2008; work in progress)

Medicare Physicians and Other Health Professionals

Place of Service Errors

We will review physician coding of place of service on 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 non-facility 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-00-06-35113; various reviews; expected issue date: FY 2008; 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," Chapter 12, section 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. The global surgery fee includes payment for a certain number of E&M services provided during the global surgery period. We will determine whether industry

Upselling of Inhalation Drugs by Suppliers

We will review how often inhalation drug suppliers switch Medicare beneficiaries from less expensive generic inhalation drugs to more expensive brand-name inhalation drugs. Prior to January 1, 2005, Medicare reimbursed for both generic and brand-name drugs based on the average wholesale price (AWP). Section 305 of the MMA mandated that, effective in 2005, both multisource and brand-name drugs be reimbursed at the amount provided under section 1847(a) of the Social Security Act. In general, section 1847(a) specifies that payment is at 106 percent of the ASP. The ASP of generic inhalation drugs is generally less than that of similar brand-name drugs; therefore, Medicare pays more for the latter than for the former. We will assess the frequency and financial impact of switching Medicare beneficiaries from less expensive generic inhalation drugs to more expensive brand-name products.
(OEI; 03-07-00440; expected issue date: FY 2008; work in progress)

Medicare Part D Administration

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 pursuant to section 402(a)(1)(A) of the Social Security Amendments of 1967 (Pub. L. No. 90-248) 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 cost, as well as certain State administrative costs. We will determine whether payments made to States for the Part D Dual-Eligible Demonstration Project are correct and supported. 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 2009; work in progress)

Duplicate Drug Claims for Hospice Beneficiaries

We will review the propriety of drug claims for individuals who are receiving hospice benefits under Medicare Part A and drug coverage under Medicare Part D. Per the "Medicare Claims Processing Manual," Chapter 11, "Processing Hospice Claims," subsection 30.2, CMS publishes the hospice payment rates, 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 was implemented in 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 such drugs. We will determine whether payments made under Part D are correct, supported, and not duplicated in hospice daily per diem amounts. We will identify the extent of duplication and the controls to prevent duplicate drug payments.
(OAS; W-00-07-35307; various reviews; expected issue date: FY 2009; new start)