of the States also use MDS data as the basis of their Medicaid payment systems. We will review CMS's processes for ensuring that nursing homes submit accurate and complete MDS data.
(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Nursing Home Residents Aged 65 or Older Who Received Antipsychotic Drugs

We will review the extent to which nursing home residents aged 65 or older received selected antipsychotic drugs in the absence of conditions approved by the Food and Drug Administration (FDA). The Social Security Act, §§ 1819 and 1919, requires SNFs to respect certain rights of patients, including the right to be free from chemical restraints administered for discipline or convenience. The regulation at 42 CFR § 483.25(l) defines safeguards to protect nursing home residents from being prescribed unnecessary drugs. We will examine Medicare Part D and Part B program reimbursements for selected antipsychotic drugs received by elderly nursing home residents and the extent to which these drugs were prescribed and paid for in accordance with Federal regulations.
(OEI; 07-08-00150; expected issue date: FY 2009; work in progress)

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 these services. The Social Security Act, § 1861(dd), 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 hospice services provided to selected beneficiaries, we will assess beneficiaries' plans of care and determine whether the services that they receive are consistent with their plans of care and whether payments are appropriate.
(OEI; 02-06-00221; expected issue date: FY 2009; work in progress)

Physician Billing for Medicare Hospice Beneficiaries

We will review the extent of Part B billing for physician services provided to Medicare hospice beneficiaries. The regulations at 42 CFR § 418.304 list the physician services that are already covered by Medicare under the hospice benefit. The regulation provides that, for physicians employed by or in an arrangement with the hospice, payments for certain services are reimbursed to the hospice as part of the hospice payment, while other services are paid to the hospice under the Part B MPFS. Physicians may receive reimbursement for hospice services under Medicare Part A or Part B. This study is a followup to recent OIG studies on hospice care. We will determine the frequency of and total expenditures for physician services under Part A and Part B for hospice beneficiaries. We will identify whether physicians double-billed hospice services to Part A and Part B.
(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Trends in Medicare Hospice Utilization

We will review Medicare Part A hospice claims to identify trends in hospice utilization. When the hospice benefit was created in section 122 of the Tax Equity and Fiscal Responsibility Act of 1982, Medicare did not cover more than 210 days of hospice care per beneficiary. Congress changed the benefit in section 4443 of the Balanced Budget Act of 1997 implemented by CMS at 42 CFR § 418.21, to eliminate the limit on the number of days covered by Medicare. Since then, the number and types of diagnoses associated with hospice utilization have increased, and longer stays have become more common. We will examine the characteristics of hospice beneficiaries, geographical variations in utilization, and differences between for-profit and not-for-profit providers.

(OEI; 00-00-00000; expected issue date: FY 2009; new start)

Physicians and Other Health Professionals

Place of Service Errors

We will review physician coding of place of service on Medicare Part B 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 nonfacility 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-00-08-35113; various reviews; expected issue date: FY 2009; 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," Pub. No. 100-04, ch. 12, § 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. We will determine whether industry practices related to the number of E&M services provided during the global surgery period have changed since the global surgery fee concept was developed in 1992.

(OAS; W-00-07-35207; various reviews; expected issue date: FY 2009 and FY 2010; work in progress)

Medicare Practice Expenses Incurred by Selected Physician Specialties

We will review the actual expenses of selected physician specialties. Physician services include medical and surgical procedures, office visits, and medical consultations. Physicians are paid for services pursuant to the MPFS, which covers the major categories of costs including the physician professional cost component, malpractice costs, and practice expense. The Social Security Act, § 1848(c)(1)(B), defines "practice expense" as the portion of the resources used in furnishing the service that reflects the general categories of expenses, such as office rent, wages of personnel, and equipment. We will determine whether Medicare payments for physician

lacking coverage. Medicare reimbursed States for beneficiaries' Part D drugs to the extent that those costs were not recoverable from Part D Plans, as well as for certain State administrative costs. We will review States' submissions of data under the Part D Dual-Eligible Demonstration Project to determine whether the payments were accurate and properly supported. We will also determine whether payments were duplicated within Part D and/or duplicated in both Part D and the Medicaid programs.
(OAS; W-00-07-35214; W-00-08-35214; various reviews; expected issue date: FY 2009; work in progress)

Duplicate Drug Claims for Hospice Beneficiaries

We will review the appropriateness 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," Pub. No. 100-04, ch. 11, § 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 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 per diem amounts. We will identify the extent of duplication and the controls to prevent duplicate drug payments.
(OAS; W-00-09-35307; various reviews; expected issue date: FY 2010; new start)

Medicare Part D Duplicate Payments

We will review the effectiveness of CMS's controls to prevent duplicate Part D monthly capitated payments to Part D sponsors for the same beneficiaries, particularly when beneficiaries change plans or try to enroll in more than one plan. When CMS has made duplicate payments, it may recoup such payments in accordance with 42 CFR §§ 423.343 and 422.308(f), which permit CMS to adjust payments retroactively to take into account any difference between the actual number of Medicare enrollees and the number on which it based an advance monthly payment. As of January 2008, there were more than 25 million beneficiaries enrolled in Part D plans. We will determine the extent to which CMS has made duplicate monthly capitated payments for individual beneficiaries to multiple plans.
(OAS; W-00-09-35408; various reviews; expected issue date: FY 2009; new start)

Duplicate Medicare Part A and Part B Claims Included With Part D Claims

We will review claims submitted for payment under Medicare Part D to determine whether they were duplicated in Medicare Part A or Part B. Pursuant to the Social Security Act, § 1860D-2(e)(2)(B), a drug prescribed for a Part D beneficiary shall not be considered for payment if the drug was prescribed and dispensed or administered under Part A or Part B. Medicare Part A covers drugs for people with Medicare who are receiving treatments as inpatients of hospitals. Drugs covered under Medicare Part B include injectable drugs administered by a physician, certain self-administered drugs, drugs used in conjunction with DME, and some vaccines. Medicare Part A and Part B do not cover most outpatient prescription