Medicare's Reconciliations of Outlier Payments

We will review Medicare outlier payments to determine whether CMS performed the necessary reconciliations in a timely manner so that Medicare contractors could perform final settlement of the associated cost reports submitted by providers. We will also examine whether MACs referred all providers that meet the criteria for reconciliations to CMS. Outliers are additional payments made for beneficiaries who incur unusually high costs. Outlier payment reconciliations must be based on the most recent cost-to-charge ratio from the cost report to properly determine outlier payments. (42 CFR § 412.84(i)(4).) Outlier payments also may be adjusted to reflect the time value of money for overpayments and underpayments. (OAS; W-00-11-35451; various reviews; expected issue date: FY 2012; new start)

Hospital Claims With High or Execessive Payments

We will review Medicare hospital claims with high payments to determine whether they were appropriate. We will also review the effectiveness of the claims processing system edits used to identify excessive payments. Our prior work has shown that claims with unusually high payments may be incorrect for various reasons. Our work will include certain outpatient claims in which payments exceeded charges and selected Healthcare Common Procedure Coding System codes for which billings appear to be aberrant. Medicare requires hospitals to report units of service as the number of times a service or procedure was performed. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 4, § 20.4.) (OAS; W-00-10-35518; W-00-11-35518; various reviews; expected issue date: FY 2012; work in progress)

Hospital Same-Day Readmissions

We will review Medicare claims to determine trends in the number of same-day hospital readmission cases. Based on prior OIG work, CMS implemented an edit (a special system control) in 2004 to reject subsequent claims on behalf of beneficiaries who were readmitted to the same hospital on the same day. If a same-day readmission occurs for symptoms related to or for evaluation or management of the prior stay's medical condition, the hospital is entitled to only one diagnosis-related group payment and should combine the original and subsequent stays into a single claim. (CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 3, § 40.2.5.) Providers are permitted to override the edit in certain situations. We will test the effectiveness of the edit. This work may also be helpful to CMS in implementing provisions of the Affordable Care Act. (OAS; W-00-10-35439; W-00-11-35439; various reviews; expected issue date: FY 2012; work in progress; Affordable Care Act)

Acute-Care Hospital Inpatient Transfers to Inpatient Hospice Care (New)

We will review Medicare claims for inpatient stays for which the beneficiary was transferred to hospice care and examine the relationship, either financial or common ownership, between the acute-care hospital and the hospice provider and how Medicare treats reimbursement for similar transfers from the acute-care setting to other settings. Regulations at 42 CFR § 412.2 state that inpatient prospective payment system (IPPS) payments to hospitals for inpatient stays are payment in full for hospitals' operating costs. Regulations state that hospice payments can be made for a general inpatient care day. (42 CFR § 318.301(b)(4) .) A general inpatient care day is one on which an individual who has elected hospice care receives general inpatient care in an inpatient facility for pain control or acute or chronic symptom management that cannot be managed in other settings. (OAS; W-00-12-35602; various reviews; expected issue date: FY 2012; new start)

Part A SNF benefit. Part B services provided during a non-Part A stay must be billed directly by suppliers and other providers. (CMS's *Medicare Benefits Policy Manual*, Pub. 100-02, ch. 8, § 70.) Congress directed OIG to monitor these services for abuse. (Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA), § 313.) A series of studies will examine podiatry, ambulance, laboratory, and imaging services. (OEI; 06-11-00280; various reviews; expected issue dates: FY 2012, 2013; work in progress)

Hospices

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

MEDPAC—MEDICARE PAYMENT ADVISORY COMMISSION
COPS—(MEDICARE) CONDITIONS OF PARTICIPATION

Hospice Marketing Practices and Financial Relationships with Nursing Facilities (New)

We will review hospices' marketing materials and practices and their financial relationships with nursing facilities. Medicare covers hospice services for eligible beneficiaries under Medicare Part A. (Social Security Act, § 1812(a).) In a recent report, OIG found that 82 percent of hospice claims for beneficiaries in nursing facilities did not meet Medicare coverage requirements. MedPAC, an independent congressional agency that advises Congress on issues affecting Medicare, has noted that hospices and nursing facilities may be involved in inappropriate enrollment and compensation. MedPAC has also highlighted instances in which hospices aggressively marketed their services to nursing facility residents. We will focus our review on hospices that have a high percentage of their beneficiaries in nursing facilities. (OEI; 02-10-00071; 02-10-00072; expected issue date: FY 2012; work in progress)

Medicare Hospice General Inpatient Care

We will review the use of hospice general inpatient care from 2005 to 2010. We will assess the appropriateness of hospices' general inpatient care claims and hospice beneficiaries' drug claims billed under Part D. Federal regulations address Medicare CoPs for hospice at 42 CFR Part 418. We will review hospice medical records to address concerns that this level of hospice care is being misused and to determine the extent to which drugs are being inappropriately billed to Part D. (OEI; 02-10-00490; expected issue date: FY 2012; work in progress)

Medical Equipment and Supplies

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

DME—DURABLE MEDICAL EQUIPEMENT
DMEPOS—DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES
DTS—DIABETIC TESTING SUPPLIES
LCD—LOCAL COVERAGE DETERMINATION
MAC—MEDICARE ADMINISTRATIVE CONTRACTOR

Characteristics Associated With Part D Billing in 2009

We will review Part D drugs billed in 2009 to identify characteristics of associated pharmacies, prescribers, and beneficiaries. We will also identify the pharmacies, prescribers, and beneficiaries associated with atypically high billing and determine what, if any, characteristics they have in common. Drug plan sponsors must submit the information necessary for the Secretary to determine payments to the plans, and the Department of Health and Human Services (HHS) has the right to inspect and audit the sponsors' records pertaining to the information. (Social Security Act, § 1860(D)-15(f)(1).) (OEI; 02-09-00600; OEI; 02-09-00603; OEI; 02-09-00604; various reviews; expected issue date: FY 2012; work in progress)

Drug Costs Paid by Part D Sponsors Under Retail Discount Generic Programs

We will review drug costs for specific Part D-covered drugs on prescription drug event (PDE) records to determine whether contracted prices between pharmacies and Part D sponsors were accurately reflected. We will also review contracts between sponsors and pharmacies and PDE records to determine the extent to which sponsors and the Federal Government have benefited from retail discount generic programs. Sponsors contract with pharmacies to dispense drugs to eligible Medicare beneficiaries and pay negotiated rates for drugs dispensed to these beneficiaries. A prescription drug plan permits the participation of any pharmacy that meets the terms and conditions under the plan. (Social Security Act, § 1860D-4(b).) (OAS; W-00-12-35510; various reviews; expected issue date: FY 2012; work in progress)

Part D Payments for Drugs Dispensed at Retail Pharmacies With Discount Generic Programs (New)

We will determine whether Part D claims were paid at the discounted prices available at certain retail pharmacies, and whether the Plan Finder Website is accurately reporting these prices to beneficiaries. In 2006, several retail chain pharmacies began offering certain generic drugs at discounted prices (e.g., $4 for a 30-day supply). Typically, sponsors should also pay these discounted prices if their contracts include a "usual and customary" clause, which means they pay the lowest price that is consistently charged at a pharmacy. These prices should also be reflected in CMS's Plan Finder Web site, which helps beneficiaries choose a prescription drug plan based on estimates of costs and coverage. (OEI; 03-11-00460; expected issue date: FY 2012; 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. We will determine whether payments under Part D are correct, supported, and not duplicated in hospice per diem amounts. We will also determine the extent of any duplication found and identify controls to prevent duplicate drug payments. Medicare Part D drug plans should not pay for drugs that are covered under the Part A hospice benefit. CMS publishes hospice payment rates, which include prescription drugs used for pain relief and symptom control related to the beneficiary's terminal illness. (*Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 11, § 30.2.) Hospice providers are paid per diem amounts, which include payments for these drugs. 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. (Social Security Act, § 1860D-2(e)(2)(B).) (OAS; W-00-10-35307; W-00-11-35307; various reviews; expected issue date: FY 2012; work in progress)

Other Medicaid Services and Payments

ACRONYMS AND ABBREVIATIONS FOR SELECTED TERMS USED IN THIS SECTION:

DME—DURABLE MEDICAL EQUIPMENT
HCBS—HOME- AND COMMUNITY-BASED SERVICES
NPI—NATIONAL PROVIDER IDENTIFIERS
OMB—OFFICE OF MANAGEMENT AND BUDGET
UPL—UPPER PAYMENT LIMITS

Hospice Services: Compliance With Reimbursement Requirements

We will determine whether Medicaid payments for hospice services complied with Federal reimbursement requirements. Medicaid may cover hospice services for individuals with terminal illnesses. (Social Security Act, § 1905(o)(1)(A).) Hospice care provides relief of pain and other symptoms and supportive services to terminally ill persons and assistance to their families in adjusting to the patients' illness and death. An individual, having been certified as terminally ill, must elect hospice coverage and waive all rights to certain otherwise covered Medicaid services. (CMS's *State Medicaid Manual*, Pub. 45, § 4305.) In FY 2010, Medicaid payments for hospice services totaled more than $816 million. (OAS; W-00-11-31385; various reviews; expected issue date: FY 2012; new start. OEI; 00-00-00000; expected issue date: FY 2013; new start)

Potentially Excessive Medicaid Payments for Inpatient and Outpatient Services

We will review State controls to detect potentially excessive Medicaid payments to institutional providers for inpatient and outpatient services. Previous OIG work involving Medicare inpatient and outpatient claims found that many excessive payments to the hospitals were attributable to billing errors on the submitted claims, such as inaccuracies in diagnosis codes, admission codes, discharge codes, procedure codes, charges, Healthcare Common Procedure Coding System codes, and number of units billed. To be allowable, costs must be necessary and reasonable for the proper and efficient performance and administration of Federal awards. (Office of Management and Budget (OMB) Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*, Att. A, § C.1.a.) Costs must be authorized, or not prohibited, under State or local laws or regulations. (§ C.1.c.) CMS adjusts quarterly payments to States to account for overpayments and underpayments by States to providers. (Social Security Act, § 1903(d)(2)(A), and 42 CFR pt. 433, subpart E.) (OAS; W-00-11-31127; various reviews; expected issue date: FY 2012; work in progress)

Payments for Physical, Occupational, and Speech Therapy Services

We will determine the extent to which payments for Medicaid physical, occupational, and speech therapy services comply with State standards and limits on coverage. Previous OIG studies found that some therapy services provided under Medicare were billed incorrectly. Through a review of selected States, we will determine whether Medicaid has similar program integrity issues. States may provide physical, occupational, and speech therapy services to Medicaid beneficiaries pursuant to the Social Secrity Act, § 1905(a), and regulations at 42 CFR § 440.110. (OEI; 07-10-00370; expected issue date: FY 2012; work in progress)

Medicaid Medical Equipment

We will determine whether Medicaid payments for medical supplies and equipment were properly authorized by physicians, the products were received by the beneficiaries, and the amounts paid were within Medicaid payment guidelines. Rules and guidance about necessary medical supplies and