

**Hospitals—Compliance With Medicare’s Transfer Policy (New)**

We will review Medicare payments made to hospitals for beneficiary discharges that should have been coded as transfers. We will determine whether such claims were appropriately processed and paid. We will also review the effectiveness of the MAC’s claims processing edits used to identify claims subject to the transfer policy. Pursuant to Federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. (42 CFR § 412.4 (e).) In contrast, a hospital that transfers a beneficiary to another facility is paid a graduated per diem rate, not to exceed the full DRG payment that would have been made if the beneficiary had been discharged without being transferred. (42 CFR§ 412.4(f).) (OAS; W-00-12-35102; various reviews; expected issue date: FY 2013; work in progress)

**Hospitals—Payments for Discharges to Swing Beds in Other Hospitals (New)**

We will review Medicare payments made to hospitals for beneficiary discharges that were coded as discharges to a swing bed in another hospital. Swing beds are inpatient beds that can be used interchangeably for either acute care or skilled nursing services. Pursuant to Federal regulations, a hospital discharging a beneficiary is paid the full DRG amount. (42 CFR § 412.4 (e).) In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another prospective payment system (PPS) hospital (42 CFR § 412.4(f).) This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged "early" and then admitted to additional care in other clinical settings. However, Medicare does not pay the reduced graduated per diem rate if that patient was discharged to a swing bed in another hospital. If appropriate, we will recommend that CMS evaluate its policy related to payment for hospital discharges to swing beds in other hospitals. (OAS; W-00-13-35700; various reviews; expected issue date: FY 2013; new start)

**Hospitals—Acute-Care Inpatient Transfers to Inpatient Hospice Care**

We will determine the extent to which acute care hospitals discharge beneficiaries after a short stay to hospice facilities. Analysis of Medicare claims data demonstrates significant occurrences of a discharge from an acute care hospital after a short stay that is immediately followed by hospice care. Medicare pays a full PPS rate to hospitals that discharge beneficiaries for hospice care (42 CFR § 412.4(e). In contrast, Medicare pays hospitals a reduced payment for shorter lengths of stay when beneficiaries are transferred to another PPS hospital or, for certain DRGs, to postacute care settings, such as a skilled nursing facility. (42 CFR § 412.4(f).) This is based on the assumption that acute care hospitals should not receive full DRG payments for beneficiaries discharged “early” and then admitted for additional care in other clinical settings. If appropriate, we will recommend that CMS evaluate its policy related to payment for hospital discharges to hospice facilities. (OAS; W-00-12-35602; various reviews; expected issue date: FY 2013; work in progress)

**Hospitals—Payments for Canceled Surgical Procedures (New)**

We will determine costs incurred by Medicare related to inpatient hospital claims for canceled surgical procedures. Our preliminary analysis of Medicare claims data for inpatient stays demonstrated significant occurrences of an initial PPS payment to hospitals for a canceled surgical procedure followed

## Hospices

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Acronyms and Abbreviations for Selected Terms Used in This Section:

MedPAC—Medicare Payment Advisory Commission  
CoPs—(Medicare) conditions of participation

### Hospices—Marketing Practices and Financial Relationships with Nursing Facilities

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 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 2013; work in progress)

### Hospices—General Inpatient Care

We will review the use of hospice general inpatient care in 2011. We will also assess the appropriateness of hospices' general inpatient care claims. 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. (OEI; 02-10-00490; expected issue date: FY 2013; work in progress)

## Home Health Services

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Acronyms and Abbreviations for Selected Terms Used in This Section:

CoP—(Medicare) conditions of participation  
HHA—home health agency

OASIS—Outcome and Assessment Information Set  
PPS—prospective payment system

### HHAs—Home Health Face-to-Face Requirement (New)

We will determine the extent to which home health agencies (HHA) are complying with a statutory requirement that physicians (or certain practitioners working with physicians) who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with the beneficiaries. (Patient Protection and Affordable Care Act (Affordable Care Act), § 6407.) The encounters must occur within 120 days: either within the 90 days before beneficiaries start home health care or up to 30 days after care begins. (42 CFR § 424.22.) OIG work conducted before the Affordable Care Act mandate went into effect found that only 30 percent of beneficiaries had at least one face-to-face visit with the

### **Dental Services for Children—Inappropriate Billing (New)**

We will review Medicaid payments by States for dental services to determine whether States have properly claimed Federal reimbursement. Dental services are required for most Medicaid -eligible individuals under age 21 as a component of the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services benefit. (Social Security Act, §§ 1905(a)(4)(B) and 1905(r).) Federal regulations define “dental services” as diagnostic, preventative, or corrective procedures provided by or under the supervision of a dentist. (42 CFR § 440.100.) Services include the treatment of teeth and the associated structure of the oral cavity and disease, injury, or impairment that may affect the oral cavity or general health of the recipient. Prior work indicates that some dental providers may be inappropriately billing for services. (OAS; W-00-10-31135; W-00-11-31135; W-00-12-31135; various reviews; expected issue date: FY 2013; work in progress)

### **Dental Services for Children—Billing Patterns in Five States (New)**

We will review billing patterns of pediatric dentists and their associated clinics in five selected States. Medicaid covers comprehensive dental care for approximately 30 million low-income children through the EPSDT benefit. Under EPSDT, States must cover dental services and dental screening services for children. OIG investigations have identified numerous vulnerabilities with pediatric dental care, particularly with the care provided by certain for-profit dental chains. (OEI; 02-12-00330; expected issue date: FY 2014; work in progress)

### **Hospice Services—Compliance With Reimbursement Requirements**

We will determine whether Medicaid payments by States 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, may 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; W-00-12-31385; various reviews; expected issue date: FY 2013; work in progress)

### **Family Planning Services—Claims for Enhanced Federal Funding**

We will review family planning services in several States to determine whether States improperly claimed enhanced Federal funding for such services and the resulting financial impact on Medicaid. Previous OIG work found improper claims for enhanced funds for family planning services. States may claim Federal reimbursement for family planning services at the enhanced Federal matching rate of 90 percent. (Social Security Act, § 1903(a)(5).) (OAS; W-00-10-31078; W-00-11-31078; W-00-12-31078; various reviews; expected issue date: FY 2013; work in progress)