Medicare Part A and Part B

Medicare Part A covers certain inpatient services in hospitals and skilled nursing facilities (SNF) and some home health services. Medicare Part B covers designated practitioners' services; outpatient care; and certain other medical services, equipment, supplies, and drugs that Part A does not cover. The Centers for Medicare & Medicaid Services (CMS) uses Medicare Administrative Contractors (MAC) to administer Medicare Part A and Medicare Part B and to process claims for both parts.

OIG has focused its efforts on identifying and offering recommendations to reduce improper payments, prevent and deter fraud, and foster economical payment policies. Future planning efforts for FY 2016 and beyond will include: additional oversight of hospice care, including oversight of certification surveys and hospice-worker licensure requirements; oversight of Skilled Nursing Facilities' (SNF) compliance with patient admission requirements; and evaluation of CMS's Fraud Prevention System.

Hospitals

Acronyms and Abbreviations for Selected Terms:

IME—indirect medical education
IMRT—intensity-modulated radiation therapy
IRF—inpatient rehabilitation facility
LTCH—long-term-care hospital
PPS—prospective payment system
RHC—right heart catheterization
SNF—skilled nursing facility

Hospital-Related Policies and Practices

➢ Reconciliations of outlier payments

We will review Medicare outlier payments to hospitals to determine whether CMS performed necessary reconciliations in a timely manner to enable Medicare contractors to perform final settlement of the hospitals' associated cost reports. We will also determine whether the Medicare contractors referred all hospitals that meet the criteria for outlier reconciliations to CMS. Outliers are additional payments that Medicare provides to hospitals for beneficiaries who incur unusually high costs. CMS reconciles outlier payments on the basis of the most recent cost-to-charge ratio from hospitals' associated cost reports. Outlier payments also may be adjusted to reflect the time value of money for overpayments and underpayments. Without timely reconciliations and final settlements, the cost reports remain open and funds may not be properly returned to the Medicare Trust Fund. (42 CFR, § 412.84(i)(4).) (OAS; W-00-14-35451; W-00-15-35451; various reviews; expected issue date: FY 2016)

Hospices

Acronyms and Abbreviations for Selected Terms:

CoP—conditions of participation

➢ **REVISED** Hospice general inpatient care

We will review the use of the general inpatient care level of the Medicare hospice benefit. We will assess the appropriateness of hospices' general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care. We will also review hospice medical records to address concerns that this level of hospice care is being billed when that level of service is not medically necessary. We will review beneficiaries' plans of care and determine whether they meet key requirements. Hospice care is palliative rather than curative. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary's terminal illness and related conditions. Federal regulations address Medicare conditions of participation (CoP) for hospices. (42 CFR Part 418.) Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time. (42 CFR § 418.28.) In addition, we will also determine whether Medicare payments for hospice services were made in accordance with Medicare requirements. (OEI; 02-10-00491; 02-10-00492; expected issue date: FY 2016; and OAS; W-00-15-35744; various reviews; expected issue date: FY 2016)

Home Health Services

Acronyms and Abbreviations for Selected Terms:

CMS—Centers for Medicare & Medicaid Services
HHA—home health agency
PPS—prospective payment system

➢ Home health prospective payment system requirements

We will review compliance with various aspects of the home health prospective payment system (PPS), including the documentation required in support of the claims paid by Medicare. We will determine whether home health claims were paid in accordance with Federal laws and regulations. A prior OIG report found that one in four home health agencies (HHAs) had questionable billing. Further, CMS designated newly enrolling HHAs as high-risk providers, citing their record of fraud, waste, and abuse. Since 2010, nearly $1 billion in improper Medicare payments and fraud has been identified relating to the home health benefit. Home health services include part-time or intermittent skilled nursing care, as well as other skilled care services, such as physical, occupational, and speech therapy; medical social work; and home health aide services. (OAS; W-00-13-35712; W-00-14-35712; W-00-15-35712; various reviews; expected issue date: FY 2016)