

# Medicare

## Medicare Hospitals

### Hospital Capital Payments

We will review Medicare inpatient capital payments. Capital payments are a hospital's expenditures for assets such as equipment and facilities. The basic methodology for determining capital prospective rates is found at 42 Code of Federal Regulations (CFR) § 412.308. We will determine whether capital payments to hospitals are appropriate. We will examine the methodology used to update capital rates and analyze the appropriateness of the payment level. *(OAS; W-00-08-35300; various reviews; expected issue date: FY 2009; new start)*

### Medicare-Dependent Hospital Program

We will review the appropriateness of FY 2002 base-year costs for a selected number of Medicare-dependent hospitals (MDH). Pursuant to section 5003(c) of the DRA, starting on October 1, 2006, payments to MDHs are based on 75 percent of its FY 2002 hospital-specific rates for discharges if that payment would result in higher Medicare payments than those under the Medicare Inpatient Prospective Payment System (IPPS). Payments to MDHs would be based on 75 percent of the FY 2002 adjusted hospital-specific costs. We will determine whether payments made to MDHs are correct and supported based on allowable costs from the FY 2002 cost reports.

*(OAS; W-00-07-35301; various reviews; expected issue date: FY 2008; work in progress)*

### Adjustments for Graduate Medical Education Payments

We will review audit adjustments for direct and indirect graduate medical education that fiscal intermediaries (FI) make while settling Medicare cost reports. Regulations governing graduate medical education payments are found at 42 CFR §§ 412.105 and 413.78 through 413.83. We will determine whether the adjustments were appropriately reflected in the revised Medicare reimbursement.

*(OAS; W-00-06-35189; various reviews; expected issue date: FY 2008; work in progress)*

### Nursing and Allied Health Education Payments

We will review payments for provider-operated nursing and allied health (NAH) education programs. The Medicare program makes payments to hospitals for provider-operated NAH programs on a reasonable-cost basis in accordance with Federal regulations at 42 CFR § 413.85. We will determine whether payments to providers for these costs were appropriate.

*(OAS; W-00-05-35-35123; various reviews; expected issue date: FY 2008; work in progress)*

### Inpatient Prospective Payment System Wage Indices

We will review hospital and Medicare controls over the accuracy of the hospital wage data used to calculate wage indices for the IPPS. Hospitals must accurately report wage data for CMS to properly calculate the wage index in accordance with section 1886(d)(3) of the Social Security Act. Our prior work found hundreds of millions of dollars in misreported wage data. We will

determine whether hospitals have complied with Medicare requirements for reporting wage data and determine the effect on the Medicare program of incorrect diagnosis-related group (DRG) reimbursement caused by inaccurate wage data. We will also examine the appropriateness of using hospital wage indices for other provider types.

*(OAS; W-00-04-35142; various reviews; expected issue date: FY 2008; work in progress)*

### **Payments to Organ Procurement Organizations**

We will review Medicare payments made to organ procurement organizations (OPO). An OPO coordinates the retrieval, preservation, and transportation of organs for transplant and maintains a system to allocate available organs to prospective recipients. Medicare reimburses OPOs under 42 CFR § 413.200 according to a cost basis method set out at 42 CFR § 413.24. We will determine whether payments made to OPOs are correct and supported.

*(OAS; W-00-06-35152; various reviews; expected issue date: FY 2008; work in progress)*

### **Inpatient Hospital Payments for New Technologies**

We will review payments made to hospitals for new services and technologies. Pursuant to sections 1886(d)(5)(K) and (L) of the Social Security Act, Medicare's new technology payments consist of payments for new medical services and technologies that qualify as "new" under 42 CFR § 412.87 and are demonstrated to be otherwise inadequately paid under the DRG system. We will determine whether hospitals have submitted claims in accordance with the criteria and were appropriately reimbursed for costs associated with the new devices and technologies.

*(OAS; W-00-08-35191; various reviews; expected issue date: FY 2008; new start)*

### **Long Term Care Hospital Payments for Interrupted Stays**

We will review certain payments made to long term care hospitals (LTCH). Pursuant to Federal regulations at 42 CFR § 412.531, special payment provisions apply to interrupted stays at LTCHs. As defined in 42 CFR § 412.531, an interrupted stay occurs when a beneficiary is discharged from an LTCH to certain kinds of facilities and then returns to the same LTCH within specified periods of time. We will determine whether payments for interrupted stays made to LTCHs were correct.

*(OAS; W-00-06-35128; A-04-06-00024; expected issue date: FY 2008; work in progress)*

### **Long Term Care Hospital Short Stay Outliers**

We will review payments for cases discharged from LTCHs with lengths of stay well below the average for their DRGs, which are referred to as short stay outliers (SSO). Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA), Pub. L. No. 106-113, mandated the implementation of a Prospective Payment System (PPS) for LTCH facilities. Between 1995 and 2003, Medicare payments for LTCHs increased from \$836 million to more than \$2.7 billion. In 2002, Medicare began paying LTCHs under a PPS based on the same DRGs as those for inpatient acute-care hospitals. However, CMS applies a larger base payment to LTCHs. Our review will focus on the distribution of and payment amounts for SSO cases. We also will review cases that only marginally exceeded the SSO threshold.

*(OEI; 01-07-00290; expected issue date: FY 2008; work in progress)*

### **Special Payment Provisions for Patients Who Are Transferred to Onsite Providers and Readmitted to Long Term Care Hospitals**

We will review the application of special payment provisions for patients who were transferred to onsite providers and readmitted to LTCHs. Pursuant to Federal regulations at 42 CFR § 412.532, if an LTCH discharges patients to specified colocated providers and directly readmits more than 5 percent of the total number of its Medicare inpatients discharged from that setting, special payment provisions apply. We will determine whether the special payment provisions were appropriately applied.

*(OAS; W-00-08-35400; expected issue date: FY 2008; new start)*

### **Special Payment Provisions for Long Term Care Hospitals Discharging Beneficiaries to Colocated or Satellite Providers**

We will review the application of special payment provisions for LTCHs discharging beneficiaries to colocated hospitals or satellite providers. Pursuant to Federal regulations at 42 CFR § 412.534, special payment provisions apply if an LTCH's or LTCH satellite facility's discharged Medicare inpatient population that was admitted to the LTCH or satellite facility from the colocated hospital exceeds the applicable threshold outlined in the regulations. In these situations, payments to the LTCH may be reduced. We will determine whether the special payment provisions were appropriately applied.

*(OAS; W-00-08-35401; expected issue date: FY 2008; new start)*

### **Critical Access Hospitals**

We will review payments made to CAHs. Pursuant to sections 1814(l)(1) and 1834(g) of the Social Security Act, CAHs are generally paid 101 percent of the reasonable costs of providing covered CAH services. Our objectives are to determine whether CAHs have met the CAH classification criteria set forth in section 1820(c)(2)(B) of the Social Security Act and conditions of participation set forth at 42 CFR 485 subpart F and whether payments made to CAHs were made in accordance with Medicare requirements.

*(OAS; W-00-07-35101; expected issue date: FY 2008; work in progress)*

### **Medicare Disproportionate Share Payments**

We will review Medicare disproportionate share (DSH) payments made to hospitals. Under section 1886(d)(5)(F)(i)(I) of the Social Security Act, Medicare makes additional payments to acute care hospitals that serve a significantly disproportionate number of low-income Medicare and Medicaid patients. Medicare DSH payments have been steadily increasing, and previous OIG work has identified overpayments in this area. We will determine whether these payments were made in accordance with Medicare criteria set forth in section 1886(d)(5)(F)(vii) of the Social Security Act. We will review various components of the calculation methodology as set forth in section 1886(d)(5)(F)(v)-(vi) of the Social Security Act, determine whether the hospitals' classifications are appropriate, and examine the total amounts of uncompensated care costs that hospitals incur.

*(OAS; W-00-08-35402; expected issue date: FY 2009; new start)*

### **Inpatient Psychiatric Facility Emergency Department Adjustments**

We will review payments made to inpatient psychiatric facilities to determine whether appropriate adjustments were made for facilities that operate emergency departments. Pursuant

to Federal regulations at 42 CFR § 412.424, some of these facilities receive an adjusted rate if they maintain a qualifying emergency department. We will determine whether appropriate rate adjustments were made.

*(OAS; W-00-08-35403; expected issue date: FY 2008; new start)*

### **Provider Bad Debts**

We will review Medicare bad debts claimed by acute care inpatient hospitals, LTCHs, inpatient rehabilitation facilities, inpatient psychiatric facilities, and SNFs to determine whether they were reimbursable. Pursuant to Federal regulations at 42 CFR § 413.89, uncollectible debts related to unpaid deductible and coinsurance amounts may be claimed as Medicare bad debt if specific criteria are met. We will determine whether the bad debt payments were appropriate under Medicare regulations and whether recoveries of prior year writeoffs were properly used to reduce the cost of beneficiary services for the period in which the recoveries were made.

*(OAS; W-00-08-35404; expected issue date: FY 2008; new start)*

### **Compliance With Medicare's Transfer Policy**

We will review coding of claims submitted by hospitals for erroneously coded discharges that should have been coded as transfers. Pursuant to Federal regulations at 42 CFR § 412.4 (e), a hospital discharging a beneficiary is paid the full DRG payment. In contrast, under 42 CFR § 412.4(f), 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. We will determine whether claims were appropriately coded.

*(OAS; W-00-07-35102; A-04-07-03035, expected issue date: FY 2008; work in progress)*

### **Payments for Diagnostic X-Rays in Hospital Emergency Departments**

We will review a sample of Medicare Part B paid claims and medical records for diagnostic x-rays performed in hospital emergency departments to determine the appropriateness of payments. Radiology services furnished by a physician are reimbursed by the Medicare Physician Fee Schedule provided the conditions for payment for radiology services at 42 CFR § 415.102 (a) and 42 CFR § 120 are met. The Medicare Payment Advisory Commission (MedPAC), in its March 2005 testimony before Congress, reported concerns regarding the increasing cost of imaging services for Medicare beneficiaries and potential overuse of diagnostic imaging services. In 2004, approximately 4.7 million diagnostic x-rays were performed in Medicare-certified hospitals with emergency departments, a 9.6-percent increase since 2001. Medicare spent approximately \$48.3 million for these services in 2004. We will determine the appropriateness of payments for diagnostic x-rays and interpretations.

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

### **Patient Care and Safety in Physician-Owned Specialty Hospitals**

We will review indicators of patient care and safety in physician-owned specialty hospitals. Hospitals are required to comply with the Federal requirements set forth in the Social Security Act at section 1861(e) to ensure that Medicare beneficiaries receive care and services pursuant to 42 CFR Part 482, Conditions for Participation for Hospitals. Concerns associated with the growth of specialty hospitals led Congress, as part of the MMA, to impose an 18-month moratorium on referrals to new physician-owned specialty hospitals. In June 2005, CMS issued

a memorandum suspending the processing of provider enrollment applications for new specialty hospitals by the Medicare FIs. As part of this review, we will also examine policies related to staffing requirements at these hospitals.

*(OEI; 02-06-00310; expected issue date: FY 2008; work in progress)*

### **Oversight of the Joint Commission Hospital Accreditation Process**

We will review CMS's policies and procedures regarding the Joint Commission hospital accreditation process. Sections 1861(e) and 1865(a) of the Social Security Act and the regulations at 42 CFR 488.5 allow institutions accredited as hospitals by the Joint Commission to be deemed to meet the Medicare Conditions of Participation for Hospitals. The Joint Commission accredits about 80 percent of the Nation's hospitals that participate in the Medicare program. In 2004, the Joint Commission revamped its hospital accreditation process, requiring hospitals to evaluate themselves, typically in the middle of the hospital's 18-month accreditation cycle, and develop action plans for performance improvement. This study will evaluate the extent and adequacy of CMS's policies and procedures regarding the Joint Commission hospital accreditation process.

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

### **Medicare Secondary Payer**

We will review Medicare payments for beneficiaries who have other insurance. Pursuant to section 1862(b) of the Social Security Act, Medicare payments for such beneficiaries are required to be secondary to certain types of insurance coverage. We will assess the effectiveness of current procedures in preventing inappropriate Medicare payments for beneficiaries with other insurance coverage. For example, we will evaluate procedures for identifying and resolving credit balance situations, which occur when payments from Medicare and other insurers exceed the providers' charges or the allowed amount.

*(OAS; W-00-08-35317; various reviews; expected issue date: FY 2008; new start)*

## **Medicare Home Health**

### **Cyclical Noncompliance in Medicare Home Health Agencies**

We will review national data on home health agencies' (HHA) survey and certification deficiencies to identify whether there are trends and patterns of cyclical noncompliance with certification standards. Section 1891(c)(2)(A) of the Social Security Act requires that CMS survey at least every 36 months the quality of care and services furnished by each HHA, as measured by indicators of medical, nursing, and rehabilitative care. We will evaluate how cyclically noncompliant HHAs perform on these indicators as compared to HHAs without histories of noncompliance and identify whether CMS applies appropriate sanctions to noncompliant HHAs.

*(OEI; 09-06-00040; expected issue date: FY 2008; work in progress)*

### **Accuracy of Data on the Home Health Compare Web Site**

We will review the extent to which the Home Health Compare Web site includes accurate and complete information on Medicare-certified HHAs. This CMS-maintained Web site provides beneficiaries and their families with information on all HHAs certified by Medicare as of

January 2003. We will also examine how CMS identifies and updates missing and incorrect information in the database.

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

### **Accuracy of Coding and Claims for Medicare Home Health Resource Groups**

We will review Medicare claims submitted by HHAs to determine the extent to which the home health resource groups (HHRG) that are used in determining payments to HHAs are accurate and supported by documentation in the medical record. Section 1895 of the Social Security Act governs the payment basis and reimbursement for claims submitted by HHAs including a case-mix adjustment using HHRGs. Medicare pays for home health episodes based on a PPS that categorizes beneficiaries into groups, referred to as HHRGs. Each HHRG has an assigned weight that affects the payment rate. We will assess the accuracy of HHRG assignment and identify potential patterns of upcoding by HHAs.

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

## **Medicare Nursing Homes**

### **Skilled Nursing Facility Consolidated Billing**

We will review Medicare Part B claims submitted by suppliers for items, supplies, or services provided to beneficiaries during Part A Medicare-covered SNF stays. Pursuant to sections 1842(b)(6)(E) and 1862(a)(18) of the Social Security Act, the supplier must bill and receive payment from the SNF, rather than from Medicare, for these items or services. Prior work has identified significant improper claims submission and reimbursement in this area, and we are continuing our work to identify additional overpayments. We will also determine whether edits in CMS's main claims-processing system, the Common Working File (CWF), are effective in detecting and preventing improper payments.

*(OAS; W-00-06-35185; various reviews; expected issue date: FY 2008; work in progress)*

### **Oversight of Medicare Skilled Nursing Facility Cost Reports**

We will review a sample of nursing facility cost reports and evaluate CMS's oversight of Medicare expenditures contained in those cost reports. Section 1888(e) of the Social Security Act established a PPS for skilled nursing facilities based on the submission of allowable cost data by SNFs. CMS has issued guidelines governing the reporting of cost data in its "Provider Reimbursement Manual." Nursing facility care accounted for 16 percent of Medicare expenditures in 2005. We will determine the extent to which CMS is monitoring Medicare nursing facility cost reports to ensure compliance with established requirements and whether submitted cost reports meet those requirements.

*(OEI; 00-00-00000; expected issue date: FY 2008; new start)*

### **Accuracy of Coding for Medicare Skilled Nursing Facility Resource Utilization Groups' Claims**

We will review a national sample of Medicare claims submitted by SNFs to determine the extent to which Resource Utilization Groups (RUG) included on SNF claims for Medicare reimbursement are accurate and supported by the residents' medical records. Section 1888(e) of the Social Security Act provides the basis for the establishment of the per diem Federal payment

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

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-00-06-35207; A-05-06-00040; expected issue date: FY 2008; work in progress)*

### **Medicare Payments for Psychiatric Services**

We will review Medicare payments for psychiatric services. Section 1862 (a)(1)(A) of the Social Security Act provides that Medicare will pay for items or services only if they are reasonable and medically necessary. We will determine whether claims submitted for psychiatric services were supported and billed in accordance with Medicare requirements.

*(OAS; W-00-07-35304; expected issue date: FY 2009; new start)*

### **Services Performed by Clinical Social Workers**

We will review services furnished by clinical social workers (CSW) to inpatients of Medicare participating hospitals or SNFs to determine whether the services were separately billed to Medicare Part B. Federal regulations at 42 CFR § 410.73 (b)(2) describe services performed by a CSW that cannot be billed as CSW services under Medicare Part B when provided to inpatients of certain facilities. We will examine Medicare Part A and Part B claims with overlapping dates of service to determine whether services performed by CSWs in inpatient facilities were separately billed to Medicare Part B.

*(OAS; W-00-08-35405; expected issue date: FY 2009; new start)*

### **Medicare Payments for Selected Physician Services**

We will review the appropriateness of Medicare Part B payments for selected physician services. Section 1861(q) of the Social Security Act describes physician services as professional services performed by physicians, including surgery; consultation; and home, office, and institutional calls. Medicare reimbursement for physician services is made on the basis of a fee schedule, which is a predetermined payment amount set forth by law. Section 1833(e) of the Social Security Act precludes payments to any provider of services unless the provider has furnished the information necessary to determine the amounts due such provider. We will review the appropriateness of Medicare payments for various types of physician services to determine whether these services were paid in accordance with Medicare requirements.

*(OAS; W-00-08-35406; expected issue date: FY 2009; new start)*

### **Medicare "Incident to" Services**

We will review Medicare claims for services furnished "incident to" the professional services of selected physicians. Medicare Part B generally pays for services "incident to" a physician's professional service; such services are typically performed by a nonphysician staff member in the physician's office. Federal regulations at 42 CFR § 410.26(b) specify criteria for "incident to" services. We will examine the Medicare services that selected physicians bill "incident to" their professional services and the qualifications and appropriateness of the staff who perform them. This study will review medical necessity, documentation, and quality of care for "incident to" services.

*(OEI; 09-06-00430; 09-06-00431; expected issue date: FY 2008; work in progress)*

### **Appropriateness of Medicare Payments for Polysomnography**

We will examine the appropriateness of payments for polysomnography services.

Polysomnography, which typically occurs at a specialized sleep clinic or center, is a type of diagnostic test in which a number of the patient's physical parameters, such as heart rate and brain activity, are measured during sleep. Section 1862(a)(1)(A) of the Social Security Act provides that Medicare will pay for services only if they are medically necessary. Medicare covers polysomnography for the diagnosis of a limited number of conditions when the testing meets particular criteria. Sleep studies are reimbursable for patients with symptoms consistent with sleep apnea, narcolepsy, impotence (the diagnosis of which can benefit from polysomnography), or parasomnia in accordance with the "Medicare Benefit Policy Manual," Pub. No. 100-02, Chapter 15, section 70. Medicare payments for polysomnography increased from \$62 million in 2001 to \$170 million in 2004. We will also examine the factors contributing to the rise in Medicare payments for polysomnography.

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

### **Long Distance Physician Claims Associated With Home Health Agency and Skilled Nursing Facility Services**

We will review the appropriateness of payments for physician services paid under Medicare Part B for beneficiaries either receiving care from Medicare HHAs or residing in SNFs while living significant distances from the physicians billing for services. Section 1861(m) of the Social Security Act defines home health services provided to Medicare beneficiaries under the Hospital Insurance (Part A) and the Supplemental Medical Insurance (Part B) benefits of the Medicare program. We will determine whether Medicare Part B physician services have been inappropriately claimed for beneficiaries receiving HHA and SNF services.

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

### **Assignment Rules by Medicare Providers**

We will review whether Medicare providers are adhering to assignment rules in billing Medicare beneficiaries. Section 1866(2)(A) of the Social Security Act precludes participating physicians/suppliers from charging Medicare beneficiaries more than the deductible and coinsurance based upon the approved Medicare payment amount determination. Providers who accept assignment must accept Medicare's payment and beneficiary copayment, referred to as the Medicare allowed amount, as payment in full for all covered services. Providers cannot "balance bill" beneficiaries for amounts in excess of the Medicare allowed amounts. We will determine the extent to which providers may be billing beneficiaries in excess of amounts allowed by Medicare requirements and assess beneficiary awareness of the potential violations.

*(OEI; 00-00-00000; expected issue date: FY 2008; new start)*

### **Business Relationships and the Use of Magnetic Resonance Imaging Under the Medicare Physician Fee Schedule**

We will review the arrangements under which magnetic resonance imaging (MRI) is provided under the Medicare Physician Fee Schedule. Section 1848 (a) (1) of the Social Security Act establishes the physician fee schedule as the basis for Medicare reimbursement for all physician services. We will describe relationships among physicians, billing providers, and others who work together to provide imaging services and determine whether these relationships affect levels of utilization. We will pay particular attention to financial relationships among the parties

involved in providing services and identify whether such relationships are associated with high use of services.

*(OEI; 01-06-00261; expected issue date: FY 2008; work in progress)*

### **Medicare Payments for Interventional Pain Management Procedures**

We will review Medicare payments for interventional pain management procedures. Section 1862(a)(1)(A) of the Social Security Act provides that Medicare will pay for services only if they are medically necessary. Interventional pain management procedures consist of minimally invasive procedures, such as needle placement of drugs in targeted areas, ablation of targeted nerves, and some surgical techniques. Many clinicians believe that these procedures are useful in diagnosing and treating chronic, localized pain that does not respond well to other treatments. Interventional pain management is a relatively new and growing medical specialty. In 2005, Medicare paid nearly \$2 billion for these procedures. We will determine the appropriateness of Medicare payments for interventional pain management procedures and assess the oversight of these procedures.

*(OEI; 05-07-00200; expected issue date: FY 2008; work in progress)*

### **Geographic Areas With High Utilization of Ultrasound Services**

We will review services and billing patterns in geographic areas with high utilization of ultrasound services paid under the Medicare Physician Fee Schedule. Our review will examine disproportionately high Medicare allowed charges and services per beneficiary and disproportionately high percentages of beneficiaries receiving ultrasound services relative to the rest of the country. Section 1848(a)(1) of the Social Security Act establishes the physician fee schedule as the basis for Medicare reimbursement for all physician services, and section 1862(a)(1)(A) provides that Medicare will pay for services only if they are medically necessary. In areas of high utilization of ultrasound services, we will examine service profiles, provider profiles, and beneficiary profiles.

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

### **Geographic Areas With a High Density of Independent Diagnostic Testing Facilities**

We will review services and billing patterns in geographic areas with high concentrations of independent diagnostic testing facilities (IDTF). An IDTF is a facility that performs diagnostic procedures and that is independent of a physician's office or hospital. It may have a fixed location or be a mobile entity, and the practitioner performing the procedures may be a nonphysician. IDTFs must meet performance requirements at 42 CFR § 410.33 to obtain and maintain Medicare billing privileges. A 2006 OIG review found numerous problems with IDTFs, including noncompliance with Medicare standards and potential improper payments of \$71.5 million. In areas with a high density of IDTFs, we will examine service profiles, provider profiles, beneficiary profiles, and billing patterns.

*(OEI; 00-00-00000; expected issue date: FY 2008; new start)*

### **Payments for High Frequency Chiropractic Treatments**

We will review chiropractor billings for high frequency treatments to determine whether they comply with Medicare coverage criteria and documentation requirements. High frequency refers to a potentially excessive number of treatments or outliers to guidelines or standards of care.

Section 1861(r)(5) of the Social Security Act defines physicians as including chiropractors, but only for treatment by manual manipulation of the spine to correct subluxations of the spine. Federal regulations at 42 CFR § 410.21(b) further limit Medicare payment to treatment of subluxations that result in a neuromusculoskeletal condition for which manual manipulation is appropriate treatment. Sections 1862(a)(1)(A) and 1833(e) of the Social Security Act provide that Medicare pay for services only if they are medically necessary and supported by documentation. Prior OIG work found that 40 percent of chiropractic services were for maintenance therapy and thus did not meet Medicare coverage criteria, potentially costing the program and its beneficiaries approximately \$186 million in improper payments. We will determine the appropriateness of Medicare payments for high frequency chiropractic claims. *(OEI; 07-07-00390; expected issue date: FY 2008; work in progress)*

### **Physician Reassignment of Benefits**

We will review the extent to which Medicare physicians reassign their benefits to other entities. Section 1842(b)(6) of the Social Security Act prohibits physicians who provide services for Medicare beneficiaries from reassigning their right to Medicare payments to other entities, unless a specific exception applies. For example, physicians are permitted to reassign to other entities enrolled in Medicare when contractual arrangements exist between the physicians and the entities that meet certain program integrity safeguards or when payments are being made to the physicians' employers. Investigations in South Florida have revealed schemes in which fraudulent providers obtain identifying information about legitimate physicians and request reassignments on their behalf. Having a large number of reassignments may be indicative of fraudulent or abusive activity. We will examine a national sample of Medicare physicians to determine the extent to which they reassign their benefits to other entities and the extent to which the physicians are aware of reassignments requested on their behalf. *(OEI; 00-00-00000; expected issue date: FY 2008; new start)*

## **Medicare Medical Equipment and Supplies**

### **Durable Medical Equipment Payments for Beneficiaries Receiving Home Health Services**

We will review Medicare claims for durable medical equipment (DME), prosthetics, orthotics, and supplies furnished to beneficiaries receiving HHA services. Section 1862(a)(1)(A) of the Social Security Act provides that Medicare pay for items and supplies only if they are medically necessary. CMS's "Medicare Benefit Policy Manual," Pub. L. No. 100-02, Chapter 15, section 110.1.C, provides additional guidance on application of the medical necessity requirement for DME. Based on OIG interviews with home health patients, there were indications of unnecessary DME being ordered for beneficiaries receiving home health services. We will determine whether DME claims paid by Medicare on behalf of beneficiaries receiving home health services were allowable.

*(OAS; W-00-07-35196; expected issue date: FY 2008; work in progress)*

### **Medicare Payments for Durable Medical Equipment Claims With Modifiers**

We will review the appropriateness of Medicare payments to DME suppliers that submitted claims with modifiers. Section 1833(e) of the Social Security Act precludes payments to any