
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 2010; work in progress)

Other Part A and Part B Providers Payments

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 Medicare Physician Fee Schedule. 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; 02-06-00224; expected issue date: FY 2010; work in progress)

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 by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), § 122, Medicare did not cover more than 210 days of hospice care per beneficiary. Congress changed the benefit in section 4443 of the BBA, 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 2011; new start)

→ Medicare Incentive Payments for E-Prescribing

We will review Medicare incentive payments made in 2010 to eligible health care professionals for their 2009 electronic prescribing (e-prescribing) activities. The Medicare Improvement for Patients and Providers Act of 2008 (MIPPA), § 132, amended the Social Security Act, § 1848(m), to provide for incentive payments to eligible health care professionals for e-prescribing beginning in 2010 and continuing through 2013. Physicians will be eligible for incentive payment if they are “successful electronic prescribers.” In its final rule for the calendar year (CY) 2009 Physician Fee Schedule, 73 Fed. Reg. 69726 (Nov. 19, 2008), CMS stated that successful electronic prescribers will be those physicians who report on CMS’s e-prescribing quality measure with respect to at least 50 percent of cases in which services are billed to Medicare Part B. We will assess whether, and, if so, the extent to which incentive payments for e-prescribing activities in 2009 were made in error. In addition, if erroneous payments were made, we will assess CMS’s actions to remedy erroneous payments and its plans for overseeing

payments made throughout the MIPPA-authorized program. This review will lay a foundation for our future evaluations of the integrity of payments authorized by the American Recovery and Reinvestment Act of 2009 (Recovery Act), including CMS's incentive payments to providers that implement electronic health records. We will identify potential vulnerabilities to assist in CMS's oversight preparations.

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

→ **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-00-09-35113; W-00-10-35113; various reviews; expected issue date: FY 2010; work in progress)

→ **Ambulatory Surgical Center Payment System**

We will review the appropriateness of the methodology for setting ASC payment rates under the revised ASC payment system. Section 626(b) of the MMA requires the Secretary to implement a revised payment system for payment of surgical services furnished in ASCs. We will examine changes to the revised ASC payment system and the rate-setting methodology used to calculate ASC payment rates.

(OAS; W-00-09-35423; W-00-10-35423; various reviews; expected issue date: FY 2010; 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-00-09-35207; W-00-10-35207; various reviews; expected issue date: FY 2010; work in progress)

→ **Medicare Payments for Part B Imaging Services**

We will review Medicare payments for Part B imaging services. Physicians are paid for services pursuant to the Medicare physician fee schedule, 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. For selected imaging services, we will focus on

the practice expense components, including the equipment utilization rate. We will determine whether Medicare payment reflects the actual expenses incurred and whether the utilization rate reflects current industry practices.

(OAS; W-00-10-35219; various reviews; expected issue date: FY 2011; 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 may not 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-00-10-35405; various reviews; expected issue date: FY 2010; new start)

Outpatient Physical Therapy Services Provided by Independent Therapists

We will review outpatient physical therapy services provided by independent therapists to determine whether they are in compliance with Medicare reimbursement regulations. The Social Security Act, § 1862(a)(1)(A), provides that Medicare will not pay for items or services that are “not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member.” CMS’s “Medicare Benefit Policy Manual,” Pub. No. 100-02, ch. 15, § 220.3, contains documentation requirements for therapy services. Previous OIG work has identified claims for therapy services provided by independent physical therapists that were not reasonable, medically necessary, or properly documented. Focusing on independent therapists who have a high utilization rate for outpatient physical therapy services, we will determine whether the services that they billed to Medicare were in accordance with Federal requirements.

(OAS; W-00-10-35220; various reviews; expected issue date: FY 2010; new start)

Appropriateness of Medicare Payments for Polysomnography

We will examine the appropriateness of Medicare payments for sleep studies. Sleep studies are reimbursable for patients with symptoms consistent with sleep apnea, narcolepsy, impotence, or parasomnia in accordance with the CMS “Medicare Benefit Policy Manual,” Pub. No. 102, ch. 15, § 70. Medicare payments for polysomnography increased from \$62 million in 2001 to \$215 million in 2005. We will also examine the factors contributing to the rise in Medicare payments for sleep studies and assess provider compliance with Federal program requirements.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Laboratory Test Unbundling by Clinical Laboratories

We will review the extent to which clinical laboratories have inappropriately unbundled laboratory profile or panel tests to maximize Medicare payments. Pursuant to the “Medicare Claims Processing Manual,” Pub. No. 100-04, ch. 16, § 90, to ensure the accuracy of payments, Medicare contractors must group together individual laboratory tests that clinical laboratories can perform at the same time on the same equipment and then consider the price of related profile tests. Payment for individual tests must not exceed the lower of the profile price or the total price of all the individual tests. We will determine whether clinical laboratories have unbundled profile or panel tests by submitting claims for multiple dates of service or by drawing

specimens on sequential days. We will also determine the extent to which the Medicare carriers have controls in place to detect and prevent inappropriate payments for laboratory tests.
(OAS; W-00-10-35222; various reviews; expected issue date: FY 2010; new start)

→ Medicare Billings With Modifier GY

We will review the appropriateness of providers' use of modifier GY on claims for services that are not covered by Medicare. CMS's "Medicare Carriers Manual," Pub. No. 14-3, pt. 3, § 4508.1, states that modifier GY is to be used for coding services that are statutorily excluded or do not meet the definition of a covered service. Beneficiaries are liable, either personally or through other insurance, for all charges associated with the provision of these services. Pursuant to CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 1, § 60.1.1, providers are not required to provide beneficiaries with advance notice of charges for services that are excluded from Medicare by statute. As a result, beneficiaries may unknowingly acquire large medical bills that they are responsible for paying. In FY 2008, Medicare received over 75.1 million claims with a modifier GY totaling approximately \$820 million. We will examine patterns and trends for physicians' and suppliers' use of modifier GY.
(OEI; 00-00-00000; expected issue date: FY 2011; 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 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; 09-09-00380; expected issue date: FY 2010; work in progress)

Enrollment Standards for Independent Diagnostic Testing Facilities

We will review IDTFs enrolled in Medicare to determine whether they meet Medicare's enrollment standards. Pursuant to Federal regulations at 42 CFR § 410.33, IDTFs, which received payments of approximately \$1 billion in 2007, are required to certify on their enrollment applications that they comply with 14 standards. Such standards include, among others, requirements that IDTFs be in compliance with all applicable Federal and State licensure and regulatory requirements for the health and safety of patients, provide complete and accurate information on their enrollment applications, and have technical staff on duty with the appropriate credentials to perform tests.
(OEI; 00-00-00000; expected issue date: FY 2010; new start)

→ Physician Reassignment of Benefits

We will review the extent to which Medicare physicians reassign their benefits to other entities. The Social Security Act, § 1842(b)(6), prohibits physicians who provide services to Medicare beneficiaries from reassigning their right to Medicare payments to other entities, unless a specific exception applies. For example, physicians are permitted to reassign benefits to other entities

enrolled in Medicare when contractual arrangements that meet certain program integrity safeguards exist between the physicians and the entities 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. We will examine the extent to which physicians are aware of their reassignments.

(OEI; 07-08-00180; expected issue date: FY 2010; work in progress)

→ **Medicare Providers' Compliance With Assignment Rules**

We will examine the extent to which providers comply with assignment rules and determine if and to what extent beneficiaries are inappropriately billed in excess of amounts allowed by Medicare requirements. Pursuant to the Social Security Act, § 1842(h)(1), physicians participating in Medicare agree to accept payment on an "assignment" for all items and services furnished to individuals enrolled in Medicare. CMS defines assignment as a written agreement between beneficiaries, their physicians or other suppliers, and Medicare. The beneficiary agrees to let the physician or other supplier request direct payment from Medicare for covered Part B services, equipment, and supplies by assigning the claim to the physician or supplier. The physician or other supplier in return agrees to accept the Medicare-allowed amount by the carrier as the full charge for the items or services provided. We will also assess beneficiaries' awareness of their rights and responsibilities regarding potential billing violations and Medicare coverage guidelines.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

→ **Payments for Services Ordered or Referred by Excluded Providers**

We will review the nature and extent of Medicare payments for services ordered or referred by excluded providers. Excluded or terminated providers, practitioners, or suppliers have engaged in fraud, program abuse, or other conduct that formed the basis for termination from Medicare, Medicaid, and all other Federal health care programs. Pursuant to the Social Security Act, §§ 1128 and 1156, no payment shall be made for any items or services furnished, ordered, or prescribed by an excluded individual or entity. In April 2009, CMS completed its transition to the use of national provider identifiers (NPI) to identify its Medicare providers. It is possible that during the transition period to NPIs, some referring or ordering providers, referred to as "secondary" providers, did not have NPIs. Secondary providers are not required to enroll in Medicare, and no edits currently exist to determine whether secondary providers have been barred, suspended, or excluded by Medicare or Medicaid, which represents a potential vulnerability. We will also examine CMS oversight mechanisms to identify and prevent improper payments for services based on orders or referrals by excluded providers.

(OEI; 00-00-00000; expected issue date: FY 2010; new start)

Ambulance Services Used To Transport End-Stage Renal Disease Beneficiaries

We will review the extent to which ambulance services are used to transport ESRD beneficiaries to and from dialysis facilities. CMS's "Medicare Benefit Policy Manual," Pub. No. 100-02, ch. 10, § 10.3, describes coverage of ambulance services to and from renal dialysis facilities for ESRD patients who require dialysis. Furthermore, section 623(f) of the MMA requires the Secretary to develop a report on a bundled PPS for ESRD services. The bundled PPS for ESRD services generally does not provide for ambulance services. In CY 2005, payments for ambulance services between beneficiaries' residences and hospital-based or freestanding ESRD

facilities were approximately \$262 million. We will examine factors such as the percentage of the population using ambulance services, the feasibility of contracting by freestanding facilities with ambulance suppliers, and the coverage policies of other health insurance programs.

(OAS; W-00-10-35417; various reviews; expected issue date: FY 2010; new start)

Medicare Payments for Transforaminal Epidural Injections


We will review Medicare claims to determine the appropriateness of Medicare Part B payments for transforaminal epidural injections. Transforaminal epidural injections are used as an interventional technique to diagnose or treat back problems, such as pain that starts in the back and radiates down the leg. The Social Security Act, § 1862(a)(1)(A), states that Medicare will cover only services that are considered reasonable and necessary. Reasonable and necessary items are those used to diagnose or treat illness or to improve the functioning of a malformed body part. Further, the Social Security Act, § 1833(e), states that payment may be made only when a provider has furnished appropriate information about the service for processing the claim. Medicare Part B physician claims for transforaminal epidural injections increased by 130 percent between 2003 and 2007. We will also determine whether there are policies and safeguards to prevent inappropriate payments for transforaminal epidural injections.

(OEI; 05-09-00030; expected issue date: FY 2010; work in progress)

Comprehensive Error Rate Testing Program: FY 2008 Transportation Claims Error Rate

We will review certain aspects of CMS's Comprehensive Error Rate Testing program (CERT) methodology for determining the FY 2008 transportation/ambulance claims error rate. The Improper Payments Information Act of 2002 (IPIA) requires Federal agencies to annually develop a statistically valid estimate of improper payments made under programs with a significant risk of erroneous payments. To accomplish our objective, we will review transportation claims that were selected for review by the FY 2008 CERT program. Our review will consist of a statistical subsample of claims from the CERT sample of transportation claims. For the sampled claims, we will review the beneficiaries' medical records, including pertinent records from physicians, to support claims from transportation providers. We will determine whether payments for services such as transporting the patient one way, mileage while the patient is on board, and all supplies and services are included in the charge and are appropriate. We will also determine whether the documentation supports the claims, whether the services were medically necessary, and whether the beneficiaries actually received the services. We will engage independent medical reviewers to determine the medical necessity and sufficiency of documentation for these claims.

(OAS; W-00-09-40035; expected issue date: FY 2010; new start)



Comprehensive Error Rate Testing Program: Fiscal Year 2008 Part A and Part B Error Rates

We will review certain aspects of CMS's CERT methodology for determining the 2008 Part A and Part B error rates. The IPIA and the Office of Management and Budget's (OMB) implementation of that act in memorandum M-06-23 require Federal agencies to annually develop statistically valid estimates of improper payments made under programs with significant risks of erroneous payments. CMS has contracted with an independent medical review organization to perform a random independent review of its CERT contractor's payment determinations for 1,000 Part A and Part B claims (excluding inpatient claims). We will

determine whether the independent medical review organization met its contractual obligations to CMS and will provide an analysis of the organization's review. We will also evaluate the methodology and medical review determinations underlying the error rate testing conducted by the CERT contractor.

(OAS; W-00-10-40043; expected issue date: FY 2010; new start)

→ **Medicare Services Billed With Dates of Service After Beneficiaries' Dates of Death**

We will review Medicare claims with dates of service after beneficiaries' dates of death to assess CMS's controls to preclude or identify and recover improper fee-for-service payments. Pursuant to 42 CFR § 406.28(e), entitlement to hospital insurance (Part A) ends with the beneficiary's day of death and 42 CFR § 407.27(a) states entitlement to supplementary medical insurance (Part B) ends on the last day of the month in which the beneficiary dies. To monitor Medicare eligibility effectively, CMS uses several computer database systems that interface with death information on the Social Security Administration's and the Railroad Retirement Board's systems. The "Medicare Financial Management Manual," Pub. No. 100-06, ch. 3, § 10, defines an overpayment as a Medicare payment that a provider received in excess of amounts due and payable under the statute and regulations. The Federal Claims Collection Act of 1966 (FCCA), United States Code (U.S.C.), Title 31 § 3711, as implemented by 31 CFR § 901.1, requires the recovery of overpayments.

(OAS; W-00-09-35435; W-00-10-35435; various reviews; expected issue date: FY 2010; work in progress)

Durable Medical Equipment and Supplies

Physician Self-Referral for Durable Medical Equipment Services

We will review Medicare payments for DME services to determine their allowability in context of Federal requirements for physician self-referral prohibitions in the Social Security Act, § 1877. Specifically, sections 1877(a)(1) and 1877(a)(2) provide that unless exceptions apply, physicians are prohibited from making referrals for furnishing designated health services to entities with which the physicians have financial relationships. Designated health services identified under the physician self-referral prohibition include DME services. We will determine the allowability of physician self-referrals to DME suppliers in which physicians held ownership interests.

(OAS; W-00-10-35503; various reviews; expected issued date: FY 2010; new start)

Medicare Payments for Various Categories of Durable Medical Equipment

We will review the appropriateness of Medicare Part B payments to DME suppliers of power mobility devices (e.g., scooters), hospital beds and accessories, oxygen concentrators, and enteral/parenteral nutrition. Pursuant to the Social Security Act, §§ 1862(a)(1)(A) and 1833(e), Medicare will not pay for items or services that are "not reasonable and necessary for the diagnosis and treatment of illness or injury or to improve the functioning of a malformed body member." Prior OIG reviews have identified issues such as Medicare payments for DME that was not ordered by physicians, not delivered to the beneficiaries, or not needed by beneficiaries. We will identify DME suppliers in selected geographic areas with high-volume claims and

Payments for Off-Label Anticancer Pharmaceuticals and Biologicals

We will review Medicare payments for drugs and biologicals used on an off-label basis in anticancer chemotherapeutic regimens. The Social Security Act, § 1861(t)(2), provides coverage of FDA-approved drugs used for off-label indications in anticancer chemotherapeutic regimens where such uses are supported in authoritative compendia identified by the Secretary of HHS. Federal regulations at 42 CFR § 414.930(b) established a process for identifying authoritative sources of information. The DrugDex, which is a drug compendium, defines drugs in the class we will review as being medically accepted even though the given tests or treatments are indicated in only some cases and even where evidence and/or expert opinions argue against efficacy. In CY 2007, Medicare payments for anticancer drugs totaled approximately \$2.7 billion. We will determine whether patients with particular indications were prescribed anticancer drugs approved by FDA for such indications before resorting to anticancer drugs not approved for those indications and, if so, whether there were improvements in the patients' medical conditions prior to use of off-label drugs. If the beneficiaries' medical conditions improved prior to use of off-label drugs, we will determine how much Medicare could have saved had anticancer drugs continued to be used within indicated usage.

(OAS; W-00-10-35504; various reviews; expected issue date: FY 2011; new start)

Potentially Fraudulent Medicare Claims for Budesonide in South Florida

We will determine whether the number of units of budesonide billed and paid under Part B in South Florida exceeded the amount of the drug distributed for sale in the area by the manufacturer and wholesalers. Previous OIG work has uncovered aberrant billing patterns for the inhalation drug budesonide billed to Medicare Part B by suppliers in South Florida. Based on an analysis of these billing patterns, we believe that a large number of these budesonide claims may be fraudulent. This study will further assess the likelihood of fraudulent activity by examining sales data and other information provided by budesonide's manufacturer and large wholesalers/distributors.

(OEI-00-00-00000; expected issue date: FY 2010; new start)

Medicare Part A and Part B Contractor Operations

Preaward Reviews of Contract Proposals

We will review the cost proposals of various bidders for Medicare contracts based on criteria in OMB Circular A-122, Cost Principles for Non-Profit Organizations. The reports produced by these reviews assist CMS in negotiating favorable and cost-beneficial contract awards.

(OAS; W-00-10-35002; various reviews; expected issue date: FY 2010; work in progress)



Contractors' Administrative Costs

We will review administrative costs claimed by various contractors for their Medicare activities, focusing on costs claimed by terminated contractors. We will determine whether the costs claimed were reasonable, allocable, and allowable under Appendix B of the Medicare contract with CMS, as well as the Federal Acquisition Regulation (FAR) at 48 CFR pt. 31. We will coordinate the selection of contractors with CMS.

(OAS; W-00-08-35005; W-00-09-35005; W-00-10-35005; various reviews; expected issue date: FY 2010; work in progress)

Medicare Summary Notice

We will review beneficiaries' use and understanding of Medicare Summary Notices (MSN). MSNs advise beneficiaries of claims paid for health care services and supplies. CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, ch. 21, § 10, contains contractor requirements for issuing MSNs. On its Web site and in the "Medicare & You" publication, CMS emphasizes the importance of checks by beneficiaries of their MSNs for any services or supplies that they do not recognize. We will review beneficiaries' experiences and understanding of MSNs.

(OEI; 00-00-00000; expected issue date: FY 2011; new start)

Quality Improvement Organizations' Beneficiary Complaint Process

We will review the extent to which Quality Improvement Organizations (QIO) notify Medicare beneficiaries and/or their representatives of the final outcomes of their quality-of-care complaints to QIOs and determine trends in the receipt and disposition of beneficiary complaints by QIOs. Pursuant to the Social Security Act, § 1154(a)(14), QIOs are required to review complaints about the quality of care Medicare beneficiaries receive and inform beneficiaries and/or their representatives of the final outcome of their complaints. OIG reviews from 1995 and 2001 found issues with the QIO process for reporting the outcomes of their quality-of-care complaints to beneficiaries. Further, in 2002 the U.S. Court of Appeals for the District of Columbia Circuit found that HHS had not implemented the requirement to notify Medicare beneficiaries and/or their representatives of the final disposition of the quality-of-care complaints they had made to QIOs.

(OEI; 00-00-00000; OAS; W-00-10-35505; various reviews; expected issue date: FY 2010; new start)



First Level of the Medicare Appeals Process

We will review the timeliness of Medicare contractors in making determinations on requests for reconsideration at the first level of the Medicare appeals. Pursuant to the Social Security Act, § 1869(a)(3)(C)(ii), Medicare contractors have 60 days to conclude a redetermination regarding a denied claim. We will review the processes Medicare contractors use to conduct first level Medicare appeals.

(OEI; 00-00-00000; expected issue date; FY 2011; new start)

Handling of Hotline Referrals

We will review CMS's handling of complaints referred by OIG from callers to the hotline. OIG operates 1-800-HHS-TIPS to receive calls alleging fraud, waste, or mismanagement in HHS programs, such as Medicare. The availability of the hotline is widely publicized on the Internet and in various publications, including CMS's "Medicare & You" booklet, which is distributed annually to Medicare beneficiaries. In 2009, the hotline referred approximately 2,580 complaints to CMS for assessment and appropriate action. We will review CMS's handling of these referrals, including its research related to the issues of the complaints, corrective actions taken, and communications with the complainants.

(OEI; 07-09-00020; expected issue date: FY 2010; work in progress)

Medicare and Medicaid Data Match Project

We will review CMS's oversight and monitoring of the Medicare and Medicaid Data Match Project (Medi-Medi) to determine whether it is meeting contractual requirements outlined in the

Medi-Medi task orders. The Medi-Medi Project was initiated in 2001 by CMS in partnership with the State of California and continues, pursuant to the Social Security Act, § 1893, to improve coordination of Medicare and Medicaid program integrity efforts. The objective of the project is to match Medicare and Medicaid data to proactively identify program vulnerabilities and potential fraud and abuse that may have gone undetected by reviewing Medicare and Medicaid program data separately. Federal regulations at 48 CFR § 42.1500 provide policies and establish responsibilities for agencies to record and maintain contractor performance information. As of 2007, there were 10 active Medi-Medi Task Orders in the States of California, Texas, Washington, Pennsylvania, North Carolina, New Jersey, New York, Florida, Ohio, and Illinois.

(OEI; 09-08-00370; expected issue date: FY 2010; work in progress)

Accuracy and Completeness of the National Provider Identifier

We will review the accuracy and completeness of the NPI registry. NPIs are unique identification numbers for health care providers. CMS regulations at 45 CFR § 162.404 require that beginning May 23, 2007 (May 23, 2008, for small health plans), NPIs be used in lieu of legacy provider identifiers when submitting claims. Providers failing to obtain their NPIs risk losing their ability to receive payment for services provided to Medicare and Medicaid beneficiaries. By May 23, 2008, all Medicare providers had to include their NPIs when submitting claims. We will determine whether providers are including NPIs on claims as required.

(OEI; 07-09-00440; expected issue date: FY 2010; work in progress)

Implementation of Payment Suspensions

We will review how CMS and its contractors implement payment suspensions intended to prevent payments to providers and suppliers suspected of fraud. Pursuant to 42 CFR § 405.371, CMS or its contractors may suspend payments to providers or suppliers based upon the existence of reliable information of an overpayment or fraud. Payment suspensions temporarily stop payment until contractors identify and determine overpayments. We will examine CMS's oversight and contractors' implementation of payment suspensions and other administrative sanctions.

(OEI; 01-09-00180; expected issue date: FY 2010; work in progress)

Collection of Medicare Overpayments Referred by Program Safeguard Contractors

We will review overpayments that program safeguard contractors (PSC) referred to claims processors for collection in 2007. The Health Insurance Portability and Accountability Act of 1996 (HIPAA), § 202(a), established the Medicare Integrity Program, which requires CMS to engage contractors to review Medicare claims, among other things, for possible overpayments. Pursuant to this provision, program safeguard contractors perform investigative work on Medicare payments to detect and deter fraud and abuse. When they identify overpayments that have been made to Medicare providers and beneficiaries, they refer them to Medicare claims processors for collection. We will examine the amount of overpayments that Medicare claims processors have collected as a result of overpayment referrals and identify the procedures that the program safeguard contractors and claims processors use to identify and track possible fraud and abuse related to the overpayments.

(OEI; 03-08-00030; various reviews; expected issue date: FY 2010; work in progress)

→ **Recovery Audit Contractors' Referrals of Potential Fraud and Abuse**

We will review CMS's oversight of Recovery Audit Contractors (RAC) during a 3-year demonstration program to determine the extent to which RACs, which are responsible for identifying Medicare overpayments and underpayments, also identified and reported potential fraud and abuse to CMS. Section 306 of the MMA directed the Secretary of HHS to conduct a demonstration project using RACs to identify Medicare underpayments and overpayments. Following the conclusion of the RAC demonstration program, CMS made the RACs a national program. For both the demonstration and national RACs, we will examine the number of cases referred to CMS, CMS's processing of those referrals, CMS's guidance and training to the demonstration RACs to identify and report potential fraud, and CMS's guidance and training to national RACs on appropriately reporting potential fraud.

(OEI; 03-09-00130; expected issue date: FY 2010; work in progress)

→ **Transition From Program Safeguard Contractors to Zone Program Integrity Contractors**

We will review the process PSCs have used to transition their work to Zone Program Integrity Contractors (ZPIC), which are assuming the PSCs' responsibility for ensuring the integrity of all Medicare-related claims. We will examine changes in the workload levels of the outgoing PSCs and incoming ZPIC contractors and determine whether benefit integrity task order activities have been performed adequately. Under section 911 of the MMA, Congress mandated that the Secretary of HHS replace existing fee-for-service contractors with MACs. CMS began its transition from PSCs to ZPICs in late 2008 and expects the transition to be complete by March 2010. As part of that change, CMS is transitioning its PSCs into ZPICs. We will also determine whether the transition is progressing as required.

(OEI; 03-09-00520; expected issue date; FY 2010; work in progress)

→ **Provider Education and Training: Medicare-Affiliated Contractors' Progressive Correction Action**

We will review the progressive corrective action (PCA) provider education and training programs conducted by selected Medicare-affiliated contractors to determine whether such programs have reduced billing and payment error rates and aberrant provider behavior. PCA is a medical review tool used by Medicare contractors. In FY 2000, CMS included PCA in its "Medicare Program Integrity Manual," Pub. 100-08, ch. 3, as a strategy for conducting medical reviews and provider education and training. Section 921(d) of the MMA directs the Secretary of HHS to coordinate education activities provided through Medicare contractors to maximize the effectiveness of Federal education efforts for providers and oversee contractors' education and training programs. We will also assess CMS's processes for overseeing the education and training programs of selected affiliated contractors.

(OEI; 00-00-00000; expected issue date; FY 2011; new start)

Contractors' Conflicts of Interest: Oversight and Monitoring by the Centers for Medicare & Medicaid Services

We will examine CMS's process for overseeing contractors' disclosures of organizational conflict-of-interest statements at the time of initial contracting and throughout the terms of the contracts. The FAR (48 CFR subpart 9.5), along with the Health and Human Services Acquisition Regulation (HHSAR) and other authorities, prescribe the responsibilities, general rules, and procedures to identify, evaluate, and resolve organizational conflicts of interest.

Appendix A: Recovery Act Work Plan

Centers for Medicare & Medicaid Services

Medicare Part A and Part B

Breach Notification and Medical Identity Theft in Medicare

We will review CMS's compliance with new breach notification requirements for personally identifiable information (PII) in the American Recovery and Reinvestment Act of 2009 (Recovery Act) and the Centers for Medicare & Medicaid Services (CMS) oversight measures in cases of medical identity theft within Medicare. Section 13402 of the Recovery Act requires entities covered by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to notify individuals of breaches of their PII. Such PII includes health information maintained by Medicare providers and contractors. Breaches of PII can facilitate the theft of health-related PII (medical identity theft). We will examine CMS's internal procedures and processes related to the Recovery Act's breach notification requirements. We will assess CMS's oversight of its contractors, plans, and sponsors regarding breach deterrence and notification and determine other steps CMS has taken to deter medical identity theft.

(OEI; 00-00-00000; expected issue date: FY 2011; new start; Recovery Act)

Medicare Incentive Payments for Electronic Health Records

We will review Medicare incentive payments made to eligible health care professionals and hospitals for adopting electronic health records (EHR) and CMS's safeguards against incentive payments made in error. Sections 4101 and 4102 of the Recovery Act authorize incentive payments over a 5-year period to physicians and hospitals that demonstrate meaningful use of certified EHR technology. Bonus payments are scheduled to begin in 2011 and continue through 2016, with payment reductions to health care professionals who fail to become meaningful users of EHRs (section 4101(b)) beginning in 2015. Bonus payments for hospitals are scheduled to begin in 2011 (section 4102). According to Congressional Budget Office (CBO) estimates, Medicare spending for incentives and payment reductions will total approximately \$18 billion between 2011 and 2019. We will review Medicare incentive payment data from calendar year 2011 to identify incentive payments made in error. If errors are identified, we will also assess CMS's actions to remedy incentive payments made in error and its plans for securing these payments for the duration of the incentive program.

(OEI; 00-00-00000; multiple reviews; expected issue date: FY 2012; new start; Recovery Act)