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Part I

Medicare Reviews

The Office of Inspector General (OIG) relies on the Department of Health & Human Services (HHS) management, policymakers in the executive branch, States, and Congress to implement the recommendations reported in our reviews. Many of our recommendations are directly implemented by organizations within HHS, and some are acted on by States that collaborate with HHS to administer, operate, and/or oversee joint programs, such as Medicaid and Head Start program grants. Congress often incorporates our recommendations into legislative actions, resulting in substantial improvements in HHS programs and operations and in funds being made available for better use. Part I of this *Semiannual Report to Congress* summarizes the significant findings and recommendations reported in our reviews of the Medicare program, which is administered by HHS's Centers for Medicare & Medicaid Services (CMS).

Medicare Part A and Part B

Hospitals

Medicare Payments for Diagnostic Radiology Services in Emergency Departments

CLAIMS DOCUMENTATION DID NOT SUPPORT MEDICARE'S PAYMENTS OF NEARLY \$38 MILLION FOR PHYSICIANS' INTERPRETATIONS OF IMAGES AND REPORTS OF CLINICAL FINDINGS. These findings related to three common types of diagnostic radiology services (computed tomography (CT), magnetic resonance imaging (MRI), and x-rays). The diagnostic and radiology services we reviewed were conducted in hospital outpatient emergency departments. Medicare payments for such services have two components: technical and professional. We reviewed the professional component, which are payments to the interpreting physicians (i.e., emergency room physicians or radiologists). We found that in 2008, Medicare allowed \$29 million for interpretation and reports of CT and MRI services and almost \$9 million for interpretation and reports of x-ray services that did not have physicians' orders as part of the medical record documentation and/or did not have documentation to support that interpretation and reports were performed. Some physicians' interpretations and reports were performed after beneficiaries left the hospital outpatient emergency departments and many interpretations and reports did not follow one or more suggested documentation practice guidelines promoted by the American College of Radiology. Our recommendations focused on provider education, adopting uniform policies, and collecting any overpayments associated with claims lacking appropriate documentation.

2011 APR *Medicare Payments for Diagnostic Radiology Services in Emergency Departments Report*. OEI-07-09-00450. [Web Summary](#). [Full Text](#).

Medicare Payments Exceeding Charges for Outpatient Services

MEDICARE PAYMENTS FOR OUTPATIENT SERVICES THAT SIGNIFICANTLY EXCEED CHARGES MAY INDICATE POTENTIAL OVERPAYMENTS. Medicare uses an outpatient prospective payment system (OPPS) to pay certain outpatient providers. Under the OPPS, the billed charges (the prices that a provider sets for its

services) generally do not affect the current Medicare payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. When we reviewed outpatient line items in which payment amounts exceeded billed charges by a significant amount, we found provider errors, including incorrect units of services, incorrect codes, a combination of those, unallowable services, and inadequate supporting documentation that caused Medicare to overpay for the services. Our recommendations to Medicare's payment contractors included recovering the overpayments, implementing system edits to identify line item payments that exceed billed charges by a prescribed amount, and using the results of our audits in provider education activities. Reviews completed during this semiannual period follow.

- **JURISDICTION 1: PALMETTO GBA, LLC.** Of 1,323 selected line items for outpatient services, 926 were incorrect and included overpayments of about \$7.5 million that had not been refunded by the beginning of our audit. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 1 for the Period January 1, 2006, Through June 30, 2009.* A-09-10-02018. May, 2011. [Web Summary](#). [Full Text](#).
- **JURISDICTION 2: NORIDIAN ADMINISTRATIVE SERVICES, LLC.** Of 1,340 selected line items for outpatient services, 930 were incorrect and included overpayments of about \$6.2 million that had not been refunded by the beginning of our audit. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 2 for the Period January 1, 2006, Through June 30, 2009.* A-09-10-02019. April, 2011. [Web Summary](#). [Full Text](#).
- **JURISDICTION 3: NORIDIAN ADMINISTRATIVE SERVICES, LLC.** Of 1,913 selected line items for outpatient services, 1,619 were incorrect and included overpayments of about \$5.8 million that had not been refunded by the beginning of our audit. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 3 for the Period January 1, 2006, Through June 30, 2009.* A-07-10-04163. May, 2011. [Web Summary](#). [Full Text](#).
- **JURISDICTION 8: NATIONAL GOVERNMENT SERVICES** – Of 1,407 selected line items for outpatient services, 957 were incorrect and included overpayments totaling \$7 million that had not been refunded by the beginning of our audit. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 8 for the Period January 1, 2006, Through June 30, 2009.* A-05-10-00017. September, 2011. [Web Summary](#). [Full Text](#).
- **JURISDICTION 9: FIRST COAST SERVICE OPTIONS, INC.** Of 326 selected line items for outpatient services, 253 were incorrect and included overpayments of about \$1.7 million that had not been refunded by the beginning of our audit. *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by First Coast Service Options, Inc., in Jurisdiction 9 for the Period January 1, 2006, Through December 31, 2007.* A-04-10-06120. August, 2011. [Web Summary](#). [Full Text](#).
- **JURISDICTION 12: HIGHMARK MEDICARE SERVICES.** Of 739 selected line items for outpatient services, 418 were incorrect and included overpayments of about \$532,000 that had not been refunded by the beginning of our audit. *Review of Medicare Payments Exceeding Charges By \$500 to \$1,000 for Outpatient Services Processed by Highmark Medicare Services in Jurisdiction 12 for the Period January 1, 2006, Through June 30, 2009.* A-03-11-00004. August, 2011. [Web Summary](#). [Full Text](#).

Review of Select Medicare Conditions of Participation and Costs Claimed at Richards Memorial Hospital from October 1, 2004, Through September 30, 2007

RICHARDS MEMORIAL HOSPITAL (THE HOSPITAL), A CRITICAL ACCESS HOSPITAL (CAH) IN ROCKDALE, TEXAS, DID NOT COMPLY WITH A MEDICARE CONDITION OF PARTICIPATION (COP), REPORTED UNALLOWABLE COSTS IN ITS MEDICARE COST REPORTS, AND DID NOT PROPERLY DISCLOSE RELATED-PARTY RENTAL COSTS. Contrary to Federal regulations, the hospital did not comply with a Medicare CoP because it did not maintain current and active network agreements with other hospitals during our audit period. The hospital also reported approximately \$1 million of unallowable costs in its fiscal year (FY) 2005, 2006, and 2007 Medicare cost reports. Specifically, the hospital reported \$804,000 in unsupported costs, \$198,000 in unallocable costs, and \$58,000 in costs unrelated to patient care. The hospital did not properly disclose \$213,000 in related-party rental costs in its Medicare cost reports. We recommended that the hospital establish and maintain network agreements with other hospitals; revise and resubmit its FY 2005, 2006, and 2007 Medicare cost reports; and ensure that it reports only allowable costs and properly discloses related-party transactions in future cost reports. This report is one of a series of reviews of CAHs' compliance with Medicare conditions of participation and other requirements.

2011 MAY *Review of Select Medicare Conditions of Participation and Costs Claimed at Richards Memorial Hospital from October 1, 2004, Through September 30, 2007.* A-05-08-00083. [Web Summary](#). [Full Text](#).

Nursing Homes

Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents

FOR THE PERIOD JANUARY 1 THROUGH JUNE 30, 2007, 51 PERCENT OF MEDICARE CLAIMS FOR ATYPICAL ANTIPSYCHOTIC DRUGS DID NOT COMPLY WITH MEDICARE REIMBURSEMENT CRITERIA, AMOUNTING TO ABOUT \$116 MILLION IN ERRONEOUS PAYMENTS. Atypical antipsychotic drugs are approved by the Food and Drug Administration (FDA) for treatment of schizophrenia and/or bipolar disorder. Fourteen percent of 2.1 million elderly (age 65 and older) nursing home residents had at least 1 claim for such drugs. Eighty-three percent of the claims were associated with off-label conditions (conditions other than schizophrenia and/or bipolar disorder) and 88 percent were associated with dementia (the condition specified in the FDA boxed warning). Twenty-two percent of claims were for drugs that were not administered in accordance with Federal standards for drug therapy in nursing homes. Recommendations included facilitating Medicare's access to information necessary to ensure accurate coverage and reimbursement determinations and taking appropriate action regarding the erroneous payments identified in our sample. Our review did not evaluate the medical decisions used to determine each resident's treatment.

2011 MAY *Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents.* OEI-07-08-00150. [Web Summary](#). [Full Text](#). Inspector General's [CNN article](#). [CBS's related news video](#).

Part B Services During Non-Part A Nursing Home Stays

THIS REVIEW PROVIDES INSIGHTS INTO PAYMENT AND UTILIZATION PATTERNS FOR PART B SERVICES IN NURSING HOMES, AS WELL AS GEOGRAPHIC DIFFERENCES, THAT WILL GUIDE FURTHER REVIEW OF PROVIDERS THAT WARRANT SCRUTINY BY OIG AND MEDICARE. Medicare paid \$4.9 billion in 2008 for Part B services during nursing home stays not paid for by Part A (referred to as non-Part A stays). Three service categories (therapy services, evaluation and management (E/M), and major and minor medical procedures) made up 58 percent of the total payment. We found that Medicare paid \$16.75 per day per beneficiary for Part B

services across all service categories and beneficiaries. The service category of dialysis services and the State of Louisiana exhibited the highest average daily payments.

2011 JUL *Payments for Medicare Part B Services During Non-Part A Nursing Home Stays in 2008.* OEI-06-07-00580. [Web Summary](#). [Full Text](#).

Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011

ALTHOUGH CHANGES MADE TO THE SKILLED NURSING FACILITY (SNF) PAYMENT SYSTEM EFFECTIVE FY 2011 WERE INTENDED BE TO BE BUDGET NEUTRAL, UNANTICIPATED BILLING PATTERNS CONTRIBUTED TO A \$2.1 BILLION (16-PERCENT) INCREASE IN MEDICARE PAYMENTS. The increase occurred from the last half of FY 2010 to the first half of FY 2011. At the same time, we found that several of the changes reduced billing for certain higher-paying groups. The data indicate that Medicare should adjust payment rates to address the significant increases in payments to SNFs. The data also show that Medicare should make changes to how SNFs account for group therapy. Further, the data highlight the need for changes to make Medicare payments more consistent with beneficiaries' care and resource needs. Based on this report, CMS has proposed a number of changes to the SNF payment system and will issue a final rule for FY 2012.

2011 JUL *Changes in Skilled Nursing Facilities Billing in Fiscal Year 2011.* OEI-02-09-00204. [Web Summary](#). [Full Text](#).

Hospice Services

Medicare Hospices That Focus on Nursing Facility Residents

MEDICARE SPENDING ON HOSPICE CARE FOR NURSING FACILITY RESIDENTS HAS GROWN NEARLY 70 PERCENT SINCE 2005. WE FOUND THAT HUNDREDS OF HOSPICES—MOST OF WHICH WERE FOR-PROFIT—HAD MORE THAN TWO-THIRDS OF THEIR BENEFICIARIES IN NURSING FACILITIES IN 2009. Hospices with a high percentage of their beneficiaries in nursing homes received more Medicare payments per beneficiary than other hospices and had beneficiaries who spent more time in care. The high-percentage hospices typically enrolled beneficiaries whose diagnoses required less complex care and who already lived in nursing facilities. We recommended that CMS monitor hospices that depend heavily on nursing facility residents and modify the payment system for hospice care in nursing facilities. The current payment structure provides incentives for hospices to seek out nursing facility beneficiaries who often receive longer but less complex care. Medicare currently pays hospices the same rate for care provided in nursing facilities as it does for care provided in other settings, such as private homes. However, unlike private homes, nursing facilities (which are often paid by third-party payers or Medicaid) are already staffed with professional caregivers and are required to provide personal care services (PCS) that are similar to hospice aide services.

2011 JUL *Medicare Hospices That Focus on Nursing Facility Residents.* OEI-02-10-00070. [Web summary](#). [Full Text](#). See also OIG's [Spotlight](#) on Hospice Care, OIG's March 2011 [Compendium, Part I](#), pp. 19 and 20, and [OEI-02-06-00221](#), all available on our Web site.

Home Health Services

Nonroutine Supplies Subject to Home Health Consolidated Billing

FOR CALENDAR YEARS (CY) 2007 AND 2008, MEDICARE FAILED TO RECOVER AN ESTIMATED \$3.4 MILLION IN OVERPAYMENTS TO DURABLE MEDICAL EQUIPMENT (DME) SUPPLIERS FOR NONROUTINE SUPPLIES SUBJECT TO HOME

HEALTH CONSOLIDATED BILLING. We identified \$24,000 in overpayments in our sample that Medicare had not recovered as of June 10, 2010. Based on our sample results, we estimated that Medicare failed to recover \$3.4 million overpaid to DME suppliers for CYs 2007 and 2008. We found that although a postpayment system edit consistently identified nonroutine supplies subject to home health consolidated billing, two Medicare payment contractors did not implement procedures to process and recover the associated overpayments in a timely manner.

Pursuant to consolidated billing, the home health agency (HHA) that establishes the beneficiary's plan of care is paid for the services and supplies (including nonroutine supplies) that are included in the home health prospective payment rate, regardless of whether they were furnished by the HHA, by an outside provider under arrangement with the agency, under any other contracting or consulting arrangement with the agency, or otherwise. Medicare payments made to outside suppliers (e.g., DME suppliers) for nonroutine supplies provided during home health care episodes are overpayments to be recovered. We recommended that Medicare recover identified and estimated overpayments for the nonsampled line items and implement procedures to ensure that Medicare's payment contractors process and recover this type of overpayment in a timely manner.

2011 APR *Review of Medicare Home Health Consolidated Billing for Calendar Years 2007 and 2008.* A-01-10-00505. [Web Summary](#). [Full Text](#).

Physician Therapy Services Provided During Home Health Episodes

MEDICARE REIMBURSEMENT POLICY PERMITS DUPLICATE PAYMENTS FOR PART B THERAPY PROVIDED TO A BENEFICIARY DURING A HOME HEALTH EPISODE—ONCE TO THE PHYSICIAN UNDER PART B AND AGAIN TO THE HHA UNDER THE HOME HEALTH PPS. Since 2003, Medicare has allowed Part B payments to physicians for therapy services furnished during episodes in which beneficiaries are receiving home health care. Medicare also includes physicians' therapy services in the home health PPS base rate paid to the HHA. As a result, Medicare pays twice. We recommended that Medicare eliminate duplicate payments when home health payments are rebased beginning in 2014 by adjusting the home health PPS rate to exclude physician-provided therapy services or by making such services subject to the home health consolidated billing requirement.

2011 MAY *Review of Physician Therapy Services Provided During Home Health Episodes in Calendar Year 2008.* A-01-09-00530. [Web Summary](#). [Full Text](#).

Medical Equipment and Supplies

Use of Surety Bonds to Recover Overpayments Made to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies: Early Findings

OUR REVIEW REVEALED THAT MEDICARE HAD NOT RECOVERED ANY DME OVERPAYMENTS THROUGH SURETY BONDS. More than 2 years after publishing a January 2009 final rule requiring certain suppliers of durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) to obtain surety bonds, CMS had not finalized procedures for recovering overpayments through such bonds. The Balanced Budget Act of 1997 (BBA) mandated that all nonexempt DMEPOS suppliers obtain a surety bond of not less than \$50,000 to receive Medicare billing privileges. Requiring surety bonds is an important program integrity tool that not only limits fraudulent suppliers' access to the program, but also serves as a means for Medicare to guarantee recoupment of some overpayments. Not using this tool leaves Medicare vulnerable to losses from fraudulent suppliers. The report contained no recommendations.

2011 SEP *Use of Surety Bonds to Recover Overpayments Made to Suppliers of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies: Early Findings.* OEI-03-11-00351. [Web Summary](#). [Full Text](#).

Questionable Billing by Suppliers of Lower Limb Prostheses

IN 2009, MEDICARE INAPPROPRIATELY PAID \$43 MILLION FOR CERTAIN TYPES AND COMBINATIONS OF LOWER LIMB PROSTHESES THAT DID NOT MEET MEDICARE REQUIREMENTS. The improper payments could have been prevented by using claims processing system edits. Lower limb prostheses are designed to replace, as much as possible, the function of a missing limb. Medicare paid an additional \$61 million for beneficiaries for whom no claims were filed by their referring physicians, raising questions about whether the physician ever evaluated the beneficiary and whether these devices were medically necessary. We found suppliers that frequently billed for unusual combinations of prostheses or for beneficiaries who had no history of an amputation or missing limb. We recommended that Medicare implement necessary claims processing system edits, strengthen monitoring of billing, implement requirements for a face-to-face encounter to establish the beneficiary's need for prostheses, revise certain local coverage determination (LCD) requirements, enhance screening for currently enrolled suppliers, and take appropriate action on suppliers with questionable billing.

2011 AUG *Questionable Billing by Suppliers of Lower Limb Prostheses.* OEI-02-10-00170. [Web Summary](#). [Full Text](#).

Most Power Wheelchairs in the Medicare Program Did Not Meet Medical Necessity Guidelines

AN ESTIMATED 61 PERCENT OF POWER WHEELCHAIRS PROVIDED TO MEDICARE BENEFICIARIES IN THE FIRST HALF OF 2007 WERE MEDICALLY UNNECESSARY OR HAD CLAIMS THAT LACKED SUFFICIENT DOCUMENTATION TO DETERMINE MEDICAL NECESSITY. The estimate was based on records submitted by suppliers that provided the power wheelchairs. Medical necessity and documentation errors varied by power wheelchair type, and prescribing physicians' records did not support the medical necessity of most power wheelchairs. We recommended that Medicare enhance reenrollment screening standards for current DMEPOS suppliers; review records from sources in addition to the supplier, such as the prescribing physician, to determine medical necessity; continue supplier and physician education; and review the suppliers of the sampled claims we found to be in error.

2011 JUL *Most Power Wheelchairs in the Medicare Program Did Not Meet Medical Necessity Guidelines.* OEI-04-09-00260. [Web Summary](#). [Full Text](#). See also [OEI-04-07-00403](#) and [OEI-04-07-00401](#); [OIG's Spotlight](#) on Power Wheelchairs; and [OIG's March 2011 Compendium, Part I](#), pp. 67 and 68, all available on our Web site.

Other Practitioners and Suppliers

Independent Diagnostic Testing Facilities' Compliance with Medicare Standards

INDEPENDENT DIAGNOSTIC TESTING FACILITIES (IDTF) IN THE MIAMI AND LOS ANGELES AREAS DID NOT COMPLY WITH MEDICARE'S REQUIREMENT THAT THEY MAINTAIN THEIR PHYSICAL FACILITIES AT THE LOCATIONS ON FILE WITH CMS AND BE OPEN DURING BUSINESS HOURS. IDTFs that do not comply with Medicare standards are subject to administrative actions, including revocation of their Medicare billing privileges. In prior site visits in 1997, [OIG](#) found that 20 percent of IDTFs were not at the locations on file with CMS.

- MIAMI – Twenty-seven of 92 Miami-area IDTFs we visited failed to comply with selected Medicare standards. As a result of a special enrollment project and routine oversight, CMS took action

against 23 of the 27 noncompliant IDTFs that our report identified. However, three IDTFs continued to receive Medicare payments while CMS was revoking their billing privileges. We recommended periodically conducting unannounced site visits to IDTFs and immediately stopping payments to IDTFs whose billing privileges are being revoked. *Miami Independent Diagnostic Testing Facilities' Compliance with Medicare Standards*. OEI-05-09-00560. August, 2011. [Web Summary](#). [Full Text](#).

- LOS ANGELES – Forty-six of 132 Los Angeles-area IDTFs we visited failed to comply with selected Medicare standards. Twenty-four IDTFs were not at locations on file with CMS and 22 were not open during business hours. Twenty-five IDTFs submitted claims representing services performed on the same dates that site reviewers visited their locations. We recommended periodically conducting unannounced site visits to IDTFs, taking action against the noncompliant IDTFs identified by our site visits, and imposing a moratorium on the new enrollment of IDTFs in the Los Angeles area. *Los Angeles Independent Diagnostic Testing Facilities' Compliance with Medicare Standards*. OEI-05-09-00561. August, 2011. [Web Summary](#). [Full Text](#).

See also OIG's [Spotlight on Independent Diagnostic Testing Facilities](#), available on our Web site.

Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors

MEDICARE CONTRACTORS OVERPAID PHYSICIANS AN ESTIMATED \$28.8 MILLION FOR INCORRECTLY CODED PLACES OF SERVICE DURING CYS 2009 AND 2008. Physicians incorrectly used nonfacility place-of-service codes for services that were actually performed in facilities such as hospital outpatient departments or ambulatory surgical centers (ASC). To account for the increased overhead expense that physicians incur by performing certain services in nonfacility locations, Medicare reimburses physicians at a higher rate. However, when physicians perform these same services in facility settings, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate. Our recommendations included recovering the overpayments we identified in our sample; and, as appropriate, recovering any overpayments associated with nonsampled services; strengthening the physician education process; developing a data match that will identify physician services at high risk for place-of-service miscoding; and recovering any identified overpayments. The two reviews completed in this semiannual period for CY 2009 and 2008 follow.

- CY 2009 – Medicare contractors nationwide overpaid physicians an estimated \$9.5 million for incorrectly coded place of service during CY 2009. *Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2009*. A-01-10-00516. September, 2011. [Web Summary](#). [Full Text](#).
- CY 2008 – Medicare contractors nationwide overpaid physicians an estimated \$19.3 million for incorrectly coded place of service during CY 2008. *Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Contractors During Calendar Year 2008*. A-01-10-00513. September, 2011. [Web Summary](#). [Full Text](#).

Part B Prescription Drugs

Cost of Alternative Drug Treatments for Age-Related Macular Degeneration

IF MEDICARE REIMBURSEMENT FOR ALL BENEFICIARIES TREATED WITH AVASTIN OR LUCENTIS FOR WET AGE-RELATED MACULAR DEGENERATION (WET AMD) HAD BEEN PAID AT THE AVASTIN RATE DURING CYS 2008 AND 2009, MEDICARE PART B WOULD HAVE SAVED APPROXIMATELY \$1.1 BILLION AND BENEFICIARIES WOULD HAVE SAVED APPROXIMATELY \$275 MILLION IN COPAYMENTS. Conversely, we calculated that if Medicare reimbursement for all beneficiaries treated with Avastin or Lucentis for wet AMD had been paid at the Lucentis rate,

Medicare Part B would have increased spending by approximately \$1.5 billion and beneficiaries would have paid approximately \$370 million more in copayments. Our recommendations included evaluating coverage and reimbursement policies and seeking such additional authorities as are necessary to limit Part B drug and biological expenditures effectively. Avastin and Lucentis (both manufactured by Genentech) are the most commonly administered Part B biologicals used to treat wet AMD, which is the leading cause of severe vision loss in people over the age of 65 in the United States.

2011 SEP *Review of Medicare Part B Avastin and Lucentis Treatments for Age-Related Macular Degeneration.* A-01-10-00514. [Web Summary](#). [Full Text](#).

Comparison of Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement of Part B Prescription Drugs

MEDICARE COULD HAVE SAVED MILLIONS OF DOLLARS ON DRUG COSTS IN RECENT YEARS IF AVAILABLE STATUTORY AUTHORITY TO ADJUST PAYMENTS HAD BEEN APPLIED. Federal law provides that if the average sales price (ASP) (which has been the basis for paying Part B drugs since 2005) of a drug exceeds the average manufacturer price (AMP) for the drug by a threshold of 5 percent, the Secretary may disregard the ASP for the drug when setting reimbursement and shall substitute the payment amount with the lesser of either the widely available market price (if any) or 103 percent of the AMP. Consistent with its statutory mandate, OIG compares ASP to AMP for Part B drugs. On the basis of our reviews, we have consistently recommended that Medicare develop a price substitution policy and lower reimbursement for drugs that exceed the 5-percent threshold. In July 2011, a proposed rule specified, among other things, the circumstances under which AMP-based price substitutions would occur. CMS plans to implement a price substitution policy beginning in the first quarter of 2012. We have also recommended expanding the price substitution policy; seeking a legislative change requiring all manufacturers of Part B-covered drugs to submit both ASPs and AMPs; and continuing to pursue appropriate actions against manufacturers that fail to comply with price-reporting requirements, including referring to OIG manufacturers that fail to submit timely ASP data.

Following are the ASP/AMP price comparison reports we issued during this semiannual period.

- **OVERVIEW OF 2009** – In 2009, the ASPs for 34 drug codes with complete AMP data exceeded AMPs by at least 5 percent in one or more quarters. If reimbursement amounts for these 34 codes had been lowered to 103 percent of the AMPs during the applicable quarters, Medicare expenditures would have been reduced by an estimated \$4.4 million from the third quarter of 2009 through the second quarter of 2010. *Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2009.* OEI-03-10-00380. April, 2011. [Web Summary](#). [Full Text](#).
- **THIRD-QUARTER 2010** – Impact on First Quarter 2011. We identified drug codes with ASPs that exceeded AMPs by at least 5 percent in the third quarter of 2010 and found that if reimbursement amounts for the codes with complete AMP data had been based on 103 percent of the AMPs during the first quarter of 2011, Medicare expenditures would have been reduced by an estimated \$10.3 million in that quarter alone. *Comparison of Third-Quarter 2010 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for First Quarter 2011.* OEI-03-11-00160. May, 2011. [Web Summary](#). [Full Text](#).
- **FOURTH-QUARTER 2010** – Impact on Second Quarter 2011. We identified drug codes with ASPs that exceeded AMPs by at least 5 percent in the fourth quarter of 2010 and found that if reimbursement amounts for the codes with complete AMP data had been based on 103 percent of the AMPs during the second quarter of 2011, Medicare expenditures would have been reduced by an estimated \$1.3 million in that quarter alone. *Comparison of Fourth-Quarter 2010 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Second Quarter 2011* (OEI-03-11-00360). July, 2011. [Web Summary](#). [Full Text](#).

- **FIRST-QUARTER 2011 – Impact on Third Quarter 2011.** We identified drug codes with ASPs that exceeded AMPs by at least 5 percent in the first quarter of 2011 and found that if reimbursement amounts for the codes with complete AMP data had been based on 103 percent of the AMPs during the third quarter of 2011, Medicare expenditures would have been reduced by an estimated \$788,000 in that quarter alone. This is OIG's 23rd report comparing ASPs to AMPs. *Comparison of First-Quarter 2011 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Third Quarter 2011.* OEI-03-11-00540. August, 2011. [Web Summary](#). [Full Text](#).

Part A and Part B Program Administration

Review of Termination Claim for Postretirement Benefits Made by Blue Cross Blue Shield of Mississippi

BLUE CROSS BLUE SHIELD OF MISSISSIPPI'S (BCBS MISSISSIPPI) ENTIRE TERMINATION CLAIM OF \$4.2 MILLION IN POSTRETIREMENT BENEFIT (PRB) COSTS FOR THE MEDICARE PART A CONTRACT WAS UNALLOWABLE FOR MEDICARE REIMBURSEMENT. We recommended that BCBS Mississippi withdraw its termination claim of \$4.2 million in PRB costs because the claim was calculated on the basis of a retroactive change in accounting practice without CMS approval. Therefore and pursuant to BCBS Mississippi's Medicare contracts, none of the costs claimed were allowable. Medicare reimburses a portion of its contractors' PRB costs. In claiming PRB costs, contractors must follow cost reimbursement principles in the Federal Acquisition Regulation and applicable Cost Accounting Standards as required by their Medicare contracts.

2011 MAY *Review of Termination Claim for Postretirement Benefits Made by Blue Cross Blue Shield of Mississippi.* A-07-11-00359. [Web Summary](#). [Full Text](#).

Medicare Contractor Information Security Program Evaluations – Fiscal Year 2009

PRICEWATERHOUSECOOPERS' (PwC) EVALUATIONS OF MEDICARE CONTRACTOR INFORMATION SECURITY PROGRAMS WERE ADEQUATE IN SCOPE AND WERE SUFFICIENT, AND IFED LLC'S (IFED) ASSESSMENTS FOR MOST OF MEDICARE DATA CENTERS TESTED WERE ADEQUATE IN SCOPE AND WERE SUFFICIENT. Federal law requires that each Medicare contractor have its information security program evaluated annually by an independent entity, and these evaluations must address eight major requirements of Federal law. OIG must submit to Congress annual reports on the results of these evaluations, to include assessments of their scope and sufficiency. PwC reported 94 security gaps at 21 Medicare contractors, and iFed reported 67 security gaps at 7 data centers. We recommended that CMS review all contractor documentation related to future data center technical assessments and ensure that the work performed complies with CMS contractual requirements. At a minimum, this should include a review of test plans to ensure that the contractor has completed all required testing procedures and a review of contractor working papers to verify that reported issues have been adequately supported.

2011 SEP *Review of Medicare Contractor Information Security Program Evaluations for Fiscal Year 2009.* A-18-10-30300. [Web Summary](#). [Full Text](#).

Medicare Part D (Prescription Drug Program)

Part D Drug Pricing and Payment-Related Reviews

Review of Medicare Payments to Prescription Drug Plans on Behalf of Deceased Enrollees

MEDICARE MADE ABOUT \$3.6 MILLION IN UNALLOWABLE PAYMENTS TO PRESCRIPTION DRUG PLAN SPONSORS FOR COVERAGE PERIODS AFTER THE ENROLLEES' MONTHS OF DEATH. However, we note that the improper payments were made on behalf of far less than 1 percent of the deceased enrollees. Also, Medicare did not always recover such payments in a timely manner. We recommended that Medicare recoup the \$3.6 million, recover improper payments in a timely manner, and implement system enhancements to prevent and detect future improper payments for deceased enrollees. The improper payments occurred because Medicare's payment systems categorized these enrollees as alive or as having different dates of death than those listed in the Social Security Administration's death master file. Although Medicare's systems had correctly stopped payments for the vast majority of deceased enrollees, they did not always identify and prevent improper payments.

2011 MAY *Review of Medicare Payments to Prescription Drug Plans on Behalf of Deceased Enrollees* (A-05-09-00027. [Web Summary](#). [Full Text](#).

Part D Administration and Program Integrity

Part D Plans Coverage of Drugs Commonly Used By Dual Eligibles

OVERALL, THE RATE AT WHICH PART D PLAN FORMULARIES INCLUDE THE 191 DRUGS COMMONLY USED BY DUAL ELIGIBLES IS HIGH, WITH SOME VARIATION. Each Medicare prescription drug plan has a list of drugs it covers. This list is called a formulary. Dual eligibles are individuals who are eligible for both Medicare and Medicaid. On average, Part D plan formularies include 96 percent of the 191 commonly used drugs. In fact, 90 percent of dual eligibles are enrolled in Part D plans that use formularies that include at least 90 percent of the commonly used drugs. We found variation in the rate at which Part D plan formularies apply utilization management tools to the drugs commonly used by dual eligibles. This review was mandated in the Patient Protection and Affordable Care Act of 2010 (Affordable Care Act).

2011 APR *Part D Plans Generally Cover Drugs Commonly Used By Dual Eligibles*. OEI-05-10-00390. Affordable Care Act. [Web Summary](#). [Full Text](#).

Medicare Prescription Drug Sponsors' Training To Prevent Fraud, Waste, and Abuse

NEARLY ALL PART D NETWORK PHARMACIES RECEIVED TRAINING TO PREVENT FRAUD, WASTE, AND ABUSE IN 2009; HOWEVER, NOT ALL SPONSORS DOCUMENTED THE TRAINING. As a condition of contracting with CMS, Part D sponsors must have plans that help them prevent fraud, waste, and abuse. These plans must include effective annual training and education on fraud, waste, and abuse for their network pharmacies. With a few exceptions, the content and source of most training materials reflected Medicare guidance, but most sponsors could not determine the extent to which the training was effective. We recommended reiterating to sponsors their responsibilities for network pharmacies' training on fraud, waste, and abuse. We also recommended that CMS use its monitoring authority to determine sponsors' compliance with training requirements and take steps to ensure that sponsors are providing training that is effective.

2011 JUL Medicare Prescription Drug Sponsors' Training To Prevent Fraud, Waste, and Abuse.
OEI-01-10-00060. [Web Summary](#). [Full Text](#).