Part I
Medicare Program Reviews

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Patient Safety and Quality of Care

Hospitals—States' Responses to Allegations of Serious Harm to Hospital Patients

Although State survey and certification agencies' (State agencies) responses on behalf of Medicare to allegations of serious harm to hospital patients were generally timely and found problems, the State agencies often missed opportunities to incorporate patient safety principles into the responses. Moreover, the Centers for Medicare & Medicaid Services (CMS) often failed to inform the Joint Commission of complaints about the hospitals it accredits, thereby impeding the Joint Commission's oversight.

Safety principles include assessing hospitals' performance improvement systems and governing bodies, monitoring hospitals for sustained improvements, and maximizing opportunities for hospitals to learn from alleged adverse events.

Together, five types of alleged in-hospital adverse events represented half or more of the complaints in our sample: sexual assault, medication error, physical abuse by hospital staff, restraint problems, and suicide. Investigations into these types of events led to the most citations for deficiencies. The hospitals' corrective actions resulted largely in training, coupled with policy and process changes.

(Recommendations—CMS should require that State surveys evaluate compliance, ensure that States monitor hospitals' corrective actions, amend guidance on State agency disclosure of the nature of complaints to hospitals, and improve communication with accreditors.) *Adverse Events in Hospitals: Medicare's Responses to Alleged Serious Events*. OEI-01-08-00590. October 2011. Web Summary. Full Text.

Identifying and Reducing Improper Medicare Payments

Hospitals—Teaching Hospitals Overcounted Residents, Causing Excess Medicare Payments

Fifty of the 66 hospitals in our sample that over counted residents on their cost reports covering fiscal years (FY) 2006 and 2007 received $1.9 million in excess Medicare reimbursement for graduate medical education (GME). The overpayments occurred because residents were claimed by more than one hospital for the same period and were counted in the Intern and Resident Information System (IRIS) as more than one full-time equivalent (FTE). There was no Federal requirement or procedure for Medicare's payment contractor to review IRIS data to determine whether a resident had overlapping rotational assignments at more than one hospital.

(Recommendations—The Medicare payment contractor should recover the excess GME payments, implement necessary adjustments and procedures, and identify and recover similar excess GME payments made outside the scope of our audit.) *Review of Resident Data Reported in the Intern and Resident Information System for Medicare Cost Reports Submitted to Highmark Medicare Services, Inc. A-02-09-01019.* January 2012. Web Summary. Full Text.

Home Health Agencies—Data Reporting, Interim Sanctions for Noncompliance, and Documentation Reviews

Medicare beneficiaries who are generally confined to their homes may be eligible to receive certain medical services at home. Home health services include part-time or intermittent skilled nursing care, as well as other skilled care services, such as physical, occupational, and speech therapy; medical social work; and home health aide services. The services are provided by certified home health agencies (HHA).

- **Data Reporting Requirements –** HHAs did not properly submit required Outcome and Assessment Information Set (OASIS) data for 6 percent of claims filed in 2009, which represented over $1 billion in Medicare payments. Among other important uses, States use OASIS data in the survey and certification of HHAs, which ensures that HHAs are meeting all Conditions of Participation (CoP) required by Medicare. CMS holds States accountable for ensuring that HHAs submit timely and accurate

OASIS data; however, it does not provide guidance on how States should oversee this process.

(Recommendations—CMS should identify all HHAs that failed to submit OASIS data and apply its 2-percent payment reduction authority, establish and implement enforcement actions for late submission of the data, and develop clear guidelines that delineate expectations regarding data accuracy and timeliness.) *Limited Oversight of Home Health Agency OASIS Data. OEI-01-10-00460*. February 2012. Web Summary. Full Text.

- **Intermediate Sanctions for Noncompliance –** CMS issued a Notice of Proposed Rulemaking (NPRM) in 1991 to implement intermediate sanctions for HHAs found to be noncompliant with Medicare's CoP; however, CMS did not issue a final rule and withdrew the NPRM in August 2000. CMS said that legislative changes and other demands impeded promulgation of a final rule. Most recently, CMS said that it anticipates publishing a new NPRM by September 2012. Intermediate sanctions, such as civil money penalties, payment suspensions, and appointments of temporary management, will provide CMS with important tools to enforce compliance. We concluded that CMS should make HHA intermediate sanctions a high priority and complete their implementation as soon as possible. *Intermediate Sanctions for Noncompliant Home Health Agencies*. *OEI-06-11-00401.* March 2012. Web Summary. Full Text.

- **Documentation of Coverage Requirements –** HHAs usually documented Medicare's coverage requirements in beneficiaries' medical records. However, for the claims we reviewed, 22 percent were in error, resulting in $432 million in improper payments. This review, which examined the medical records supporting a sample of HHA's claims to Medicare, showed that HHAs' records nearly always documented the information necessary to demonstrate compliance with key Medicare coverage requirements—that beneficiaries were homebound, needed skilled nursing care or therapy services, and were under the care of a physician. However, other Office of Inspector General (OIG) reviews and investigations, as well as joint efforts between the Department of Health and Human Services (HHS) and the Department of Justice (DOJ), have demonstrated that home health is an area at increased risk for fraud. We concluded that further reviews beyond the medical records are needed to determine whether beneficiaries are actually eligible, services are furnished, and Medicare requirements for payment are met. *Documentation of Coverage Requirements for Medicare Home Health Claims*. *OEI-01-08-00390.* March 2012. Web Summary. Full Text.

Portable X-Ray Suppliers—Questionable Billing Patterns

Medicare paid portable x-ray suppliers in our sample for questionable return trips to nursing facilities and paid for improper claims for services that were ordered by nonphysicians and therefore were not covered. Portable x-rays constitute a small portion of overall Medicare payments for diagnostic imaging services, but the questionable claims patterns we found raise concerns about the integrity of payments to certain suppliers.

(Recommendations—CMS should take action on the specific suppliers we referred, resolve and collect the portion of the $12.8 million transportation component that was improper, collect $6.6 million in overpayments ordered by nonphysicians, and implement procedures and controls to ensure that Medicare pays for portable x-ray services only when ordered by a physician.) *Questionable Billing Patterns of Portable X-Ray Suppliers*. OEI-12-10-00190. December 2011. Web Summary. Full Text.

Independent Diagnostic Testing Facilities—Questionable Billing Patterns

Twenty high-utilization geographic areas, called Core Based Statistical Areas (CBSA), accounted for 10.5 percent of Medicare Part B payments for independent diagnostic testing facilities (IDTF) services despite having only 2.2 percent of the total population of beneficiaries. IDTFs offer diagnostic services and are independent of physicians' offices or hospitals. Almost four times more beneficiaries in high-utilization CBSAs received IDTF services than beneficiaries in all other CBSAs. Nine percent of the IDTFs that served beneficiaries in high-utilization CBSAs provided 90.1 percent of IDTF services. Additionally, high-utilization CBSAs had twice as many claims with at least two questionable characteristics as all other CBSAs. IDTF services have historically been vulnerable to abuse.

(Recommendations—CMS should monitor IDTF claims for questionable characteristics, take appropriate action when IDTFs submit a high number of questionable claims, and assess whether to impose a temporary moratorium on new IDTF enrollments in CBSAs with high concentrations of IDTFs.) *Questionable Billing for Medicare Independent Diagnostic Testing Facility Services*. OEI-09-09-00380. March 2012. Web Summary. Full Text.

Outpatient Services—Payments Exceeding Charges Prone to Errors, Overpayments

Our review of outpatient line items for which Medicare payments significantly exceeded billed charges revealed frequent errors, including

incorrect units of services, incorrect codes, a combination of those, billing for unallowable services, and inadequate supporting documentation, causing Medicare to overpay for the services. Billed charges are the prices that a provider sets for its services. Medicare uses the outpatient prospective payment system (OPPS) to pay certain outpatient providers. Under the OPPS, the amount that Medicare pays the provider is generally less than the billed charges and the billed charges generally should not affect the current Medicare payment amounts.

This review focused on billings in which Medicare's payments significantly exceeded billed charges. Millions of dollars in overpayments have occurred in part because key Medicare systems (the Fiscal Intermediary Standard System and the Common Working File (CWF) did not have sufficient edits in place during our audit periods to prevent or detect the overpayments.

(Recommendations—Medicare's payment contractors should recover their overpayments, implement suggested system edits, and use the results of our audits in provider education activities.) Following are 13 reviews of this matter that we completed during this semiannual period.

- (Recommendation—Recover $12 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by TrailBlazer Health Enterprises, LLC, in Jurisdiction 4 for the Period January 1, 2006, Through June 30, 2009. A-06-10-00045*. January 2012. Web Summary. Full Text.
- (Recommendation—Recover $6.3 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services, Inc., in Jurisdiction 6 - Illinois and Wisconsin for the Period January 1, 2006, Through June 30, 2009*. A-05-10-00025. December 2011. Web Summary. Full Text.
- (Recommendation—Recover $3.6 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 6 - Minnesota for the Period January 1, 2006, Through June 30, 2009*. A-05-10-00020. September 2011. Web Summary. Full Text.
- (Recommendation—Recover $ 2.2 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Pinnacle in Jurisdiction 7 for the Period January 1, 2006, Through June 30, 2009. A-06-10-00046*. December 2011. Web Summary. Full Text.

- (Recommendation—Recover $5.2 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services but Transitioned to Palmetto GBA, LLC, in Jurisdiction 11 for the Period January 1, 2006, Through June 30, 2009*. A-03-10-00005. November 2011. Web Summary. Full Text.
- (Recommendation—Recover $2.4 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by TriSpan but Transitioned to Pinnacle in Jurisdiction 7 for the Period January 1, 2006, Through June 30, 2009*. A-06-10-00048. October 2011. Web Summary. Full Text.
- (Recommendation—Recover $847,000 in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by First Coast Service Options, Inc., in Jurisdiction 9 for the Period January 1, 2008, Through June 30, 2009*. A-04-10-06128. November 2011. Web Summary. Full Text.
- (Recommendation—Recover $1.9 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Cahaba Government Benefit Administrators, LLC, in Jurisdiction 10 for the Period January 1, 2008, Through June 30, 2009*. A-04-10-06127. November 2011. Web Summary. Full Text.
- (Recommendation—Recover $2.8 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Cahaba Government Benefit Administrators, LLC, in Jurisdiction 10 for the Period January 1, 2006, Through December 31, 2007*. A-04-10-06121. November 2011. Web Summary. Full Text.
- (Recommendation—Recover $4.7 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 11 for the Period January 1, 2006, Through June 30, 2009*. A-03-10-00006. October 2011. Web Summary. Full Text.
- (Recommendation—Recover $7.7 million in identified overpayments.) *Review of Select Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 13 for the Period January 1, 2006, Through June 30, 2009*. A-02-10-01008. October 2011. Web Summary. Full Text.
- (Recommendation—Recover $3.2 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by NHIC, Corp., in Jurisdiction 14 for the Period January 1, 2006,*

Through June 30, 2009. A-01-10-00502. December 2011. Web Summary. Full Text.

- (Recommendation—Recover $5 million in identified overpayments.) *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 15 for the Period January 1, 2006, Through June 30, 2009*. A-05-10-00016. October 2011. Web Summary. Full Text.

Avoiding Waste in Part B Prescription Drug Pricing

Comparison of Drug-Pricing Points—Impact on Reimbursement

Since the implementation of the average sales price (ASP) prescription drug reimbursement methodology, OIG has issued 27 reports comparing ASPs to average manufacturer prices (AMP) and widely available market prices (WAMP). Twenty-five reports compared ASPs to AMPs and 2 reports compared ASPs to WAMPs. Federal law requires OIG to conduct the reviews. If OIG finds that the ASP of a drug exceeds either the AMP or the WAMP by a certain threshold (currently 5 percent), the Secretary of Health and Human Services may disregard the ASP for the drug when setting reimbursement amounts. Although CMS has yet to make any changes to Part B drug reimbursement as a result of these reviews, the agency published a final rule in November 2011 that specifies the circumstances under which AMP-based price substitutions will occur, effective January 2012. Reports issued during this semiannual period follow.

- **Comparison of ASP to AMP in the Second Quarter of 2011 –** ASPs for 40 drug codes exceeded AMPs by at least 5 percent. Of these, 26 had complete AMP data. If reimbursement amounts for all 26 codes had been based on 103 percent of the AMPs in the fourth quarter of 2011, Medicare would have saved an estimated $15.8 million in the fourth quarter. *Comparison of Second-Quarter 2011 Average Sales Prices and Average Manufacturer Prices: Impact on Medicare Reimbursement for Fourth Quarter 2011. OEI-03-12-00020.* January 2012. Web Summary. Full Text.

- **Overview of 2010 –** Medicare expenditures could have been reduced by an estimated $13.2 million from the third quarter of 2010 through the second quarter of 2011. In a comparison of ASP to AMPs across

4 quarters in 2010, ASPs for 32 drug codes with complete AMP data exceeded AMPs by at least 5 percent in one or more quarters. If reimbursement amounts for these 32 codes had been lowered to 103 percent of the AMPs during the applicable quarter(s), Medicare expenditures would have been reduced by an estimated $13.2 million from the third quarter of 2010 through the second quarter of 2011. This report summarized data across all four quarters of 2010.

(Recommendations—CMS should consider expanding the substitution policy to include drug codes with partial AMP data and seek legislative change requiring all manufacturers to submit ASPs and AMPs for Part B drugs.) *Comparison of Average Sales Prices and Average Manufacturer Prices: An Overview of 2010.* OEI-03-11-00410. November 2011. Web Summary. Full Text.

- **Comparison of ASP to WAMP –** This review was to compare ASPs to WAMPs for 14 drugs that have been identified in previous OIG reports as repeatedly exceeding the 5-percent ASP-AMP threshold. However, limitations and irregularities in sales data provided by the distributors and manufacturers called into question the data's accuracy and reliability.

  The WAMPs we calculated varied widely from other pricing points; therefore, we could not accurately determine whether any of the drugs exceeded the ASP-WAMP threshold. The limitations and irregularities in the sales data provided by the distributors and manufacturers prevented us from measuring WAMPs against the threshold. Because of limitations in the distributor-reported data, most of the sales data we received did not reflect discounts and rebates that were passed on to providers. Further, the total number of units sold that were reported to us differed substantially from the number reported to CMS through quarterly ASP submissions, potentially causing our data to reflect an inaccurate number of sales.

  We will consider alternative methodologies that will allow us to conduct future ASP-WAMP pricing comparisons, including directly surveying providers to obtain accurate and complete sales data. C*omparison of Average Sales Prices to Widely Available Market Prices for Selected Drugs*. *OEI-03-10-00280.* January 2012. Web Summary. Full Text.

Preventing and Detecting Medicare Fraud

Comprehensive Outpatient Rehabilitation Facilities in South Florida—Several Facilities Not Located or Not Operational

Of 101 South Florida Comprehensive Outpatient Rehabilitation Facilities (CORF) included in our analysis, 18 were not operational. Ten of the eighteen CORFs were not at the locations on file with CMS and 8 were not open during business hours. Medicare allowed $2.2 million in 2010 for services billed by the nonoperational CORFs. CORFs provide multidisciplinary outpatient rehabilitation services at a single location. In 2010, more than 25 percent of all CORFs nationwide were in South Florida.

This program integrity initiative review was limited to determining whether the CORFs could be located and were open during business hours. In prior reviews at three South Florida CORFs, we estimated that each audited CORF received between $720,000 and $1.6 million for services that did not meet Medicare reimbursement requirements. CMS contracts with State survey agencies to assess the prospective CORF's compliance with certain Federal regulations.

(Recommendations—CMS should continue to periodically conduct unannounced site visits to CORFs and implement additional program safeguards for CORFs.) *South Florida Medicare Comprehensive Outpatient Rehabilitation Facilities*. OEI-05-10-00090. November 2011. Web Summary. Full Text. See also prior reports: A-04-05-02009, A-04-05-02010, and A-04-05-02011.

Medical Equipment Suppliers—Some Newly Enrolled Suppliers Cause Program Integrity Problems for Medicare

CMS revoked billing privileges or placed on prepayment claims review 26 percent of high/medium-risk suppliers and 2 percent of low/limited-risk suppliers of medical equipment and supplies during their first year of enrollment in Medicare. Some suppliers received significant Medicare reimbursement before CMS took enforcement action.

A CMS contractor, the National Supplier Clearinghouse (NSC), reviews supplier enrollment applications, conducts unannounced site visits before and after enrollment, and assigns newly enrolled suppliers a risk rating based on an assessment of fraud risk. Many suppliers had omitted required information from their Medicare enrollment applications, demonstrating

that omitted information can remain undetected for more than a year despite NSC's processes.

(Recommendations—CMS should conduct earlier postenrollment site visits for the highest paid new suppliers, apply investigative techniques to identify unreported supplier owners or managers, and take appropriate action regarding suppliers that omit information from applications.) *Program Integrity Problems With Newly Enrolled Medicare Equipment Suppliers*. OEI-06-09-00230. December 2011. Web Summary. Full Text.

Medicare Program Oversight and Benefit Integrity Contractors

CMS contracts with several entities, including Program Safeguard Contractors (PSC), Medicare Drug Integrity Contractors (MEDIC), Zone Program Integrity Contractors (ZPIC), and Recovery Audit Contractors, to perform many Medicare integrity functions. OIG work continues to reveal persistent problems with CMS's program and benefit integrity contractors and ongoing vulnerabilities in CMS's oversight.

Inadequate Procedures, Data Limitations Obstruct Program Oversight

CMS's systems and procedures and those used by its contractors were not sufficient to ensure full collection of identified overpayments, resolution of known vulnerabilities, and effective oversight of contractor operations and performance.

- **Contractor-Identified Vulnerabilities –** CMS had not resolved, or taken significant action to resolve, 77 percent of vulnerabilities that its Medicare benefit integrity contractors reported in 2009. The estimated impact of the vulnerabilities, such as those in claims coding and provider identifiers, which contractors reported inconsistently or not at all, was at least $1.2 billion. Only two of the vulnerabilities reported in 2009 had been resolved as of January 2011. Although CMS has procedures to consistently track and review vulnerabilities, it lacks procedures to ensure that vulnerabilities are resolved.

  (Recommendations—CMS should determine the status of all unresolved vulnerabilities and take action to address them, require contractors to report monetary impact, and ensure that vulnerabilities are resolved by establishing formal written procedures.) *Addressing Vulnerabilities*

Reported by Medicare Benefit Integrity Contractors. OEI-03-10-00500. December 2011. Web Summary. Full Text.

- **Data Deficiencies Obstructed CMS's Oversight of ZPICs –** The workload data that CMS uses to oversee ZPICs were not accurate or uniform, and inaccuracies and lack of uniformity in the ZPICs' data prevented us from making a conclusive assessment of ZPICs' activities. ZPICs are replacing PSCs and will perform Medicare Part A and Part B benefit integrity work in seven newly established geographical zones. The inaccuracies and lack of uniformity in ZPICs' data resulted from system issues in CMS's Analysis, Reporting, and Tracking System (CMS ARTS); ZPIC reporting errors; ZPICs' interpretations of workload definitions; and inconsistencies in requests for information reports. ZPICs' performance evaluations contained few workload statistics, and data access issues affected ZPICs' program integrity activities. The conditions are serious obstacles to CMS's oversight of ZPIC operations and effectiveness.

  (Recommendations—CMS should clarify definitions in CMS ARTS; perform a timely review of data in CMS ARTS; and use and report ZPIC workload statistics in ZPIC evaluations.) *Zone Program Integrity Contractors' Data Issues Hinder Effective Oversight*. OEI-03-09-00520. November 2011. Web Summary. Full Text.

Fee-for-Service Error Rate Calculations Could Be More Accurate

CMS's Comprehensive Error Rate Testing (CERT) program contractors collect and review documents supporting claims for payment, identify improper payments, and calculate a national Medicare fee-for-service error rate. We found the following issues in current CERT practices.

- **Impact of Pending Appeals –** A CERT contractor's error rate calculations did not account for pending appeals. If the CERT statistical contractor had included overturned CERT claim payment denials in its error rate calculations, it would have decreased the estimated value of reported errors for FYs 2009 and 2010 by approximately $2 billion each year. (Recommendation—CMS should improve the accuracy of the reported estimate of improper payment error rates by including an adjustment for overturned CERT claim payment denials.) *Review of CERT Errors Overturned Through the Appeal Process for FYs 2009 and 2010*. A-01-11-00504. March 2012. Web Summary. Full Text.

- **Impact of Insufficient Documentation** – A CERT contractor did not initially obtain all necessary documentation that would have overturned the claim payment denials used in the FY 2010 error rate calculation. Doing

so could have reduced the estimate of improper payments for FY 2010 by almost $1 billion.

(Recommendations—CMS should continue to educate providers on the documentation required, assess the improper payments and overturned denials of claim payments to identify the population that would benefit from additional requests for medical records, and ensure that the CERT documentation contractor follows established procedures in seeking signature attestations.) *Pilot Project to Obtain Missing Documentation Identified in the Fiscal Year 2010 CERT Program Audit*. A-01-11-00502. February 2012. Web Summary. Full Text.

Medicare Part A and Part B Contract Administration

Medicare Part B and End-Stage-Renal-Disease and Contractors

- **Medicare Part B Contractor's Administrative Costs –** Wisconsin Physicians Service Insurance Corporation (WPS), a Part B carrier under contract with CMS to process and pay claims submitted by health care providers, reported unallowable administrative costs for Medicare.

  (Recommendations—decrease the FY 2007 Final Administrative Cost Proposal (FACP) by $1.7 million and decrease the FY 2008 FACP by $1.8 million to eliminate the unallowable costs identified in this report.) *Audit of Medicare Part B Administrative Costs for the Period October 1, 2006, Through September 30, 2008, at Wisconsin Physicians Service Insurance Corporation*. A-05-09-00096. November 2011. Web Summary. Full Text.

- **Medicare Part B contractor's Pension Costs –** HealthNow New York Inc. (HealthNow), which administers Medicare Part B and Durable Medical Equipment Regional Carrier operations under cost reimbursement contracts with CMS, overstated the pension costs it reported to Medicare. (Recommendations—HealthNow should revise the FACPs for FYs 1995 through 2006 to reduce claimed Medicare pension costs by $3.9 million or refund the amount to CMS.) *Review of Pension Costs Claimed for the Medicare Part B Segment by HealthNow New York Inc. for Fiscal Years 1995 Through 2006. A-07-11-00364.* March 2012. Web Summary. Full Text.

- **End-Stage-Renal-Disease (ESRD) Contractor's Travel, Other Direct Costs –** Southern California Renal Disease Council, Inc. (Council), one of 18 ESRD Network Organizations that contract with CMS to ensure the effective and efficient administration of ESRD program benefits, claimed for reimbursement unallowable travel and other direct costs.

  (Recommendations—Council should refund $19,996 for unallowable travel and other direct costs, work with CMS to resolve $2.2 million set aside for further analysis and refund unallowable amounts, and strengthen controls over accountability.) *Southern California Renal Disease Council, Inc., Claimed Unallowable and Unsupported Costs Under Medicare Contract Number 500-03-NW18*. A-09-10-02045. March 2012. Web Summary. Full Text.

Medicare Part C and Part D Reviews

Medicare Advantage Organizations' Identification of Potential Fraud and Abuse Varies Widely

Of 170 Medicare Advantage (MA) organizations we reviewed, 33 (19 percent) did not identify any potential fraud and abuse incidents in 2009 in either their Part C health benefits or their Part D prescription drug benefits. Further, MA organizations that identified incidents varied significantly in the number of incidents reported, raising questions about whether MA organizations are implementing their program integrity programs effectively. The 137 organizations identified about 1.4 million incidents of potential Part C and Part D fraud and abuse in 2009. However, 95 percent of the 1.4 million incidents were identified by only 3 of the organizations.

Differences in the way the organizations defined and detected potential fraud and abuse may account for some of the variability in the number of incidents they identified. CMS does not require MA organizations to report, nor does CMS routinely review, the results of the organizations' fraud and abuse program efforts.

(Recommendations—CMS should ensure the implementation of MA organizations' fraud and abuse programs, determine the reasons for unusually high or low volumes of incidents reported, and develop specific guidance.) *Medicare Advantage Organizations' Identification of Potential*

Fraud and Abuse. *OEI-03-10-00310.* February 2012. Web Summary. Full Text.

Sponsors Lack Information To Ensure Part D Drugs Are Used Only for Medically Accepted Indications

Selected Prescription Drug Plan (PDP) sponsors were unable to systematically ensure that payments for Part D drugs were limited to drugs provided for medically accepted indications because their prepayment strategies are limited and their postpayment reviews do not focus on medically accepted indications.

To qualify for Medicare Part D reimbursement, the drugs provided must be used for medically accepted indications. Medically accepted indications include uses approved by the Food and Drug Administration (FDA) and uses supported by one or more of three compendia specified in the Social Security Act. The selected PDP sponsors did not routinely collect diagnosis information, except when using prior authorization.

In short, the sponsors lacked access to information necessary for appropriate reimbursement of Part D drugs. CMS's comments on the findings are available in the full text of the report. *Ensuring That Medicare Part D Reimbursement Is Limited to Drugs Provided for Medically Accepted Indication*. OEI-07-08-00152. November 2011. Web Summary. Full Text.

Stronger Controls Needed to Identify Prescriptions Written by Excluded Providers

For calendar years (CY) 2006 through 2008, Medicare accepted Prescription Drug Event (PDE) data with gross drug costs totaling $15.1 million for prescriptions written by excluded providers (those who have been excluded by OIG from participating in Medicare, Medicaid and all Federal health care programs). Also, CMS accepted additional PDE data with gross drug costs of nearly $2 million for prescriptions that also may have been written by excluded providers.

Federal law prohibits payment under Federal health care programs for prescriptions written by excluded providers when the person dispensing the prescription knows or has reason to know of the exclusion. CMS maintains a database of excluded providers, the Medicare Exclusion Database (MED). CMS accepted PDE data submitted by sponsors for prescriptions written by excluded providers because it had inadequate internal controls in place to prevent the errors.

(Recommendations—CMS should resolve the improper payments, revise its CY 2006–2008 final payment determinations, and implement several steps we proposed to strengthen its controls over PDE data and detecting excluded providers.) *Review of Excluded Providers in the Medicare Part D Program*. A-07-10-06004. December 2011. Web Summary. Full Text.

CMS's Mandatory and Discretionary Auditing of Medicare Part D Sponsors Could Be Improved

- **Mandatory Audits –** CMS did not fully comply with mandatory Federal requirements that it annually perform audits for a full one-third of its Part D prescription drug plan sponsors. CMS excluded certain contracts subject to audit because it interpreted the statutory requirement as allowing it to do so. CMS also had not updated its standard operating procedures for audit resolution to reflect actual practices and to ensure that sponsors reported corrective actions to CMS in a timely manner. This diminished CMS's ability to ensure that corrective action was taken as rapidly as possible.

  (Recommendations—CMS should conduct the required audits and update its procedures.) *Review of the Centers for Medicare & Medicaid Services' Audits of Part D Sponsors' Financial Records*. A-03-10-00007. November 2011. Web Summary. Full Text.

- **Discretionary Audits –** CMS does not always conduct or follow through on discretionary audits of PDP sponsors. Of 125 unique sponsor contracts active during the first 4 years of the Part D program, 50 contracts, which covered 1.1 million beneficiaries, were never audited in any way. Of the 68 contracts that were active for all 4 years, 13 contracts were never audited. CMS did not complete any compliance plan audits during the 4-year period.

  As part of its oversight responsibilities for Medicare Part D, CMS identified seven types of audits, other than financial audits, that it would use for reviewing stand-alone contracts in the first 4 years of the Part D program. CMS is not required by law to conduct any of these audits, and it has no directives regarding the number of audits it should conduct. CMS selects auditees on the basis of risk analysis and other factors. For the audits CMS did conduct, it did not always have evidence to show that all problems were addressed for certain audit types.

  (Recommendations—CMS should establish a comprehensive Part D auditing strategy to ensure that each plan sponsor will be audited in some way within a certain timeframe and ensure that evidence is

available to show that corrective actions have been implemented.) *Audits of Medicare Prescription Drug Plan Sponsors*. OEI-03-09-00330. December 2011. Web Summary. Full Text.

Data About Physicians Opting Out of Medicare Insufficient for Program Oversight

Lack of Data Hinders Program Oversight of Physicians Opting Out of Medicare

CMS, Medicare Administrative Contractors (MACs), and legacy carriers (Medicare claims payment contractors that remain in jurisdictions not yet awarded to MACs) do not maintain sufficient data for analysis regarding physicians who opt out of Medicare. CMS issued guidance in 2011 that addresses the procedures that MACs and legacy carriers must have in place for maintaining data on physicians who opted out on or after January 1, 2009.

Monitoring the number of opted-out physicians and their specialties is important to ensure that Medicare beneficiaries have sufficient access to providers, including specialized providers. Additionally, having appropriate data on opted-out physicians is essential to ensuring that such physicians are not inappropriately receiving Medicare payments.

We sought to obtain data on opted-out physicians from CMS and from individual MACs and legacy carriers and were unable to answer our issue questions because no centralized data exist and the data that we received from MACs and legacy carriers were insufficient or were not provided at all. Specifically, we could not determine the characteristics of physicians who opt out of Medicare, the trend in the number of opted-out physicians, and the reason why physicians choose to opt out of Medicare

We plan to conduct a full evaluation when a complete data source of opted-out physicians is available. *Lack of Data Regarding Physicians Opting Out of Medicare*. *OEI-07-11-00340.* January 2012. Web Summary. Full Text.