OFFICE OF INSPECTOR GENERAL
U.S. Department of Health and Human Services

FY2016 Work Plan

Hospice specific

REVISED Hospice general inpatient care

We will review the use of the general inpatient care level of the Medicare hospice benefit.

- We will assess the appropriateness of hospices’ general inpatient care claims and the content of election statements for hospice beneficiaries who receive general inpatient care.
- We will also review hospice medical records to address concerns that this level of hospice care is being billed when that level of service is not medically necessary.
- **NEW!** We will review beneficiaries’ plans of care and determine whether they meet key requirements.

Hospice care is palliative rather than curative. When a beneficiary elects hospice care, the hospice agency assumes the responsibility for medical care related to the beneficiary’s terminal illness and related conditions. Federal regulations address Medicare conditions of participation (CoP) for hospices. (42 CFR Part 418.) Beneficiaries may revoke their election of hospice care and return to standard Medicare coverage at any time. (42 CFR § 418.28.) In addition, we will also determine whether Medicare payments for hospice services were made in accordance with Medicare requirements. (OEI; 02-10-00491; 02-10-00492; expected issue date: FY 2016; and OAS; W-00-15-35744; various reviews; expected issue date: FY 2016)

Medicare Part A and Part B Future Plans

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

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

**NEW Physician home visits—reasonableness of services**

We will determine whether Medicare payments to physicians for evaluation and management home visits were reasonable and made in accordance with Medicare requirements. Since January 2013, Medicare made $559 million in payments for physician home visits. Physicians are required to document the medical necessity of a home visit in lieu of an office or outpatient visit. Medicare will not pay for items or services that are not "reasonable and necessary." (Social Security Act, §1862(a)(1)(A)) (OAS; W-00-15-35754; expected issue date: FY 2016)

**NEW Prolonged services—reasonableness of services**

We will determine whether Medicare payments to physicians for prolonged evaluation and management (E/M) services were reasonable and made in accordance with Medicare requirements. Prolonged services are for additional care provided to a beneficiary after an evaluation and management service has been performed. Physicians submit claims for prolonged services when they spend additional time beyond the time spent with a beneficiary for a usual companion evaluation and management service. The necessity of prolonged services are considered to be rare and unusual. The Medicare Claims Process (MCP) manual includes requirements that must be met in order to bill a prolonged E/M service code. (MCP manual, Pub. 100-04, Ch. 12, Sec. 30.6.15.1(OAS; W-00-15-35755; expected issue date: FY 2016)

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NHPCO