



DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



June 4, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Medicare Continues To Pay Twice for Nonphysician Outpatient Services
Provided Shortly Before or During an Inpatient Stay (A-01-10-00508)

The attached final report provides the results of our review of Medicare payments for nonphysician outpatient services provided under the inpatient prospective payment system.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-01-10-00508 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE CONTINUES TO PAY
TWICE FOR NONPHYSICIAN
OUTPATIENT SERVICES
PROVIDED SHORTLY BEFORE OR
DURING AN INPATIENT STAY**



Daniel R. Levinson
Inspector General

June 2012
A-01-10-00508

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act in 1965, provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Under the inpatient prospective payment system (IPPS), hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment amount represents the total Medicare payment for the inpatient operating costs associated with a beneficiary's hospital stay. Accordingly, hospitals generally receive no additional payments for nonphysician outpatient services furnished shortly before and during inpatient stays.

CMS employs Medicare contractors to process and pay hospital inpatient and outpatient claims. Medicare contractors use the Fiscal Intermediary Standard System (FISS) to process inpatient and outpatient claims submitted by the hospitals in their designated jurisdictions. After being processed through the FISS, and prior to payment, all Medicare contractor claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization. Both the FISS and CWF systems contain edits to prevent and detect overpayments for nonphysician outpatient services furnished shortly before and during inpatient stays. Once the CWF has processed a claim, it electronically transmits a trailer record to the contractor. The trailer record includes information regarding potential errors on the claim.

Our nationwide audit covered 148,302 Medicare Part B nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays and valued at \$12,015,014 for calendar years (CY) 2008 and 2009.

OBJECTIVE

Our objective was to determine whether Medicare payments were correct for nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays.

SUMMARY OF FINDINGS

Medicare payments were not always correct for nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays. Medicare payments were correct for 66 of the 127 nonphysician outpatient services that we sampled. However, for 61 services we sampled, Medicare paid providers twice—as part of the IPPS and again under Part B—which resulted in total overpayments of \$340,073.

Based on our sample results, we estimated that Medicare contractors made approximately \$6.4 million in overpayments to hospital outpatient providers during CYs 2008 and 2009 for services provided to beneficiaries within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays. These overpayments occurred because provider controls failed to prevent or detect incorrect billing, providers were unaware that beneficiaries were inpatients at other facilities, and providers were unaware of or did not understand Medicare requirements. In addition, (1) Medicare contractors were not aware of incoming CWF alerts because CMS did not notify them it had changed the location of this information on the trailer record, (2) existing CWF edits did not prevent or detect certain incorrect payments, and (3) Medicare contractors incorrectly overrode FISS edits or took no action to recover or offset overpayments when they received CWF alerts.

RECOMMENDATIONS

We recommend that CMS:

- instruct its Medicare contractors to:
 - recover the \$340,073 in identified overpayments, to the extent allowed under the law, for the 61 incorrectly billed services;
 - work with the Office of Inspector General to resolve the remaining 148,175 services with potential overpayments estimated at approximately \$6.1 million and recover overpayments to the extent allowed under the law;
 - take action to reject claims or recoup overpayments when identified by edits; and
 - remind hospitals of the importance of adequate controls to prevent incorrect billing for services provided to beneficiaries within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays;
- communicate with Medicare contractors about changes to the CWF;
- modify existing edits to prevent payments for ambulance services provided during inpatient stays; and
- modify existing edits to prevent payments that are already included in the basic prospective payment rate for nonphysician outpatient services furnished to beneficiaries after the beneficiaries have exhausted their Part A benefits.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred in part with our first recommendation. Specifically, it stated that it would attempt to collect \$284,538 in overpayments from 42 of the 61 billed services that were not outside of the 4-year reopening period for collections and/or below the estimated cost of collection. CMS concurred with the remainder of the first recommendation, the second recommendation, and the fourth recommendation and described its efforts to implement them. CMS stated that it did not concur with our third recommendation as it was stated in the report. CMS verified that the existing alert was working correctly, but acknowledged that the alert listed an incorrect bypass scenario, which deterred the contractor from acting on the alert. CMS stated that it will update the CWF documentation and instructions in the alert to correct the bypass scenario. CMS expects to complete this during fiscal year 2012. CMS's comments are included in their entirety as Appendix D.

We furnished CMS with the information it requested to initiate recovery action.

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INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act (the Act) in 1965, provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Inpatient Prospective Payment System

Under the inpatient prospective payment system (IPPS), hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries, as long as the beneficiary has at least one benefit day at the time of admission.¹ The prospective payment amount represents the total Medicare payment for the inpatient operating costs associated with a beneficiary's hospital stay.² Inpatient operating costs include routine services, ancillary services (e.g., radiology and laboratory services), special care unit costs, malpractice insurance costs, and preadmission services. Accordingly, hospitals generally receive no additional payments for nonphysician outpatient services furnished shortly before and during inpatient stays.

Medicare Contractors and Medicare Claims Processing Systems

CMS employs Medicare contractors to process and pay Medicare inpatient and outpatient claims from hospitals.³ Each Medicare contractor is responsible for processing claims submitted by hospitals within 1 of 15 designated regions, or jurisdictions, of the United States and its territories.⁴

¹ A "benefit period" is a period of time for measuring the use of hospital insurance benefits. It is a period of consecutive days during which medical benefits for covered services are available to a beneficiary. A benefit period begins on the day of hospital admission and ends when the beneficiary has not had any inpatient care for 60 days in a row. A beneficiary may be eligible for as many as 150 days of hospital care in a benefit period—90 days of hospital care and an additional 60 lifetime reserve days.

² In addition to payments based on the prospective payment rates for inpatient operating costs, hospitals can also receive payments for the costs related to outlier cases, graduate medical education, certain items excluded from the prospective payment rates, bad debts, serving a significant number of end-stage renal disease beneficiaries, serving a disproportionate share of low-income patients, and blood clotting factor furnished to hemophilia patients.

³ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, requires CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. In this report, the term "Medicare contractor" means either the fiscal intermediary or the MAC.

⁴ In July 2010, CMS announced that it would consolidate the 15 MAC jurisdictions into 10 MAC jurisdictions in a phased process that will take several years to complete.

Medicare contractors use the Fiscal Intermediary Standard System (FISS) to process inpatient and outpatient claims submitted by hospitals in their designated jurisdictions. After being processed through the FISS, and prior to payment, all Medicare contractor claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization. Once the CWF has processed a claim, it electronically transmits a trailer record to the contractor. The trailer record includes information regarding potential errors on the claim.

System Edits To Detect and Prevent Overpayments

Both the FISS and CWF systems contain edits to prevent and detect overpayments for nonphysician outpatient services furnished shortly before and during inpatient stays. If an inpatient claim is processed and paid before a related outpatient claim is processed, prepayment edits are designed to deny payment for the nonphysician outpatient services included in the IPPS payment.

If an outpatient claim for nonphysician services provided within 3 days prior to the date of admission for or on the date of admission for an IPPS stay is processed and paid before a related inpatient claim, prepayment edits are designed to deny payment for the inpatient claim. If an outpatient claim for nonphysician services provided during an IPPS stay is processed and paid before a corresponding inpatient claim, postpayment edits are designed to generate an "alert" that identifies overpayments for the nonphysician outpatient services included in the IPPS payment. The Medicare contractor responsible for the outpatient claim is also responsible for recovering the overpayment.

Prior Office of Inspector General Reports

Prior Office of Inspector General (OIG) reviews identified significant overpayments to IPPS hospitals for nonphysician services furnished shortly before, or during, inpatient stays. In those reviews, we had recommended that CMS recover overpayments, ensure that edits to prevent such overpayments were in place and working properly, and educate providers on the proper billing of nonphysician outpatient services. CMS generally concurred with our recommendations and implemented them (Appendix A).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare payments were correct for nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays.

Scope

Our nationwide audit covered 148,302 Medicare Part B nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during

(excluding date of discharge) IPPS stays and valued at \$12,015,014 for calendar years (CY) 2008 and 2009.

Our objective did not require an understanding or assessment of the complete internal control structure of the providers or Medicare contractors that processed the claims. Therefore, we limited our review to: 1) obtaining an understanding of providers' procedures for submitting claims for nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays, and 2) Medicare contractors' procedures for processing and paying claims for those nonphysician outpatient services.

Our fieldwork consisted of contacting the outpatient providers that billed for the items we sampled and the inpatient hospitals that billed for the associated IPPS stays. We also contacted Medicare contractors and CMS officials. We conducted our fieldwork from November 2010 through June 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays for CYs 2008 and 2009;
- identified 3 strata from which we selected our sample items (stratum 1 consisted of 144,128 line items with paid amounts less than \$496, stratum 2 consisted of 4,147 line items with paid amounts of at least \$496 and less than \$20,000, and stratum 3 consisted of 27 line items with paid amounts of \$20,000 or greater);
- selected a stratified random sample of 127 line items, 50 each from strata 1 and 2, and all 27 line items from stratum 3 (Appendix B), and, for the sampled line items, we:
 - reviewed available claims histories from the CWF and FISS for each nonphysician outpatient service and corresponding inpatient stay we sampled to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork and
 - contacted 165 providers that billed for the nonphysician outpatient services and/or the corresponding inpatient stays we sampled to validate payments, determine the underlying causes of improper billing, and verify the admission and discharge dates;
- contacted CMS and four contractors to obtain an understanding of the billing requirements and edits in place in the CWF and FISS;

- used our sample results to estimate the overpayments that Medicare contractors made for nonphysician outpatient services provided in CYs 2008 and 2009 (Appendix C); and
- discussed the results of our review with CMS.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Medicare payments were not always correct for nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays. Medicare payments were correct for 66 of the 127 nonphysician outpatient services that we sampled. However, for 61 services we sampled, Medicare paid providers twice—as part of the IPPS and again under Part B—which resulted in total overpayments of \$340,073.

Based on our sample results, we estimated that Medicare contractors made approximately \$6.4 million in overpayments to hospital outpatient providers during CYs 2008 and 2009 for services provided to beneficiaries within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays. These overpayments occurred because provider controls failed to prevent or detect incorrect billing, providers were unaware that beneficiaries were inpatients at other facilities, and providers were unaware of or did not understand Medicare requirements. In addition, (1) Medicare contractors were not aware of incoming CWF alerts because CMS did not notify them it had changed the location of this information on the trailer record, (2) existing CWF edits did not prevent or detect certain incorrect payments, and (3) Medicare contractors incorrectly overrode FISS edits or took no action to recover or offset overpayments when they received CWF alerts.

PROGRAM REQUIREMENTS

Pursuant to section 1886(a)(4) of the Act and the *Medicare Claims Processing Manual*, Pub. No. 100-04 (Processing Manual), ch. 3, § 40.3.B, diagnostic services provided to a beneficiary by the admitting hospital⁵ within 3 days prior to and including the date of the beneficiary's admission are inpatient services that are included in the inpatient payment. Diagnostic services are identified on the claim by specific revenue center and/or Healthcare Common Procedure Coding System codes. This provision does not apply to ambulance services and maintenance renal dialysis.

⁵ This includes any entity wholly owned or operated by the admitting hospital or another entity under arrangements with the admitting hospital.

Pursuant to section 1886(a)(4) of the Act and ch. 3, § 40.3.C of the Processing Manual, nondiagnostic outpatient services that are related to a patient's hospital admission and provided by the hospital to the patient during the 3 days immediately preceding and including the date of the beneficiary's inpatient admission are inpatient services that are included in the inpatient payment. However, these preadmission nondiagnostic services are considered related to the inpatient admission only when there is an exact match between the principal diagnosis codes for the preadmission services and the inpatient stay.⁶ This provision does not apply to ambulance services and maintenance renal dialysis.

Pursuant to ch. 3, § 10.4 of the Processing Manual and the *Medicare Benefit Policy Manual* Pub. No. 100-02 (Benefit Manual), ch. 1, § 50, ch. 3, § 20.1, and ch. 6, § 10, outpatient services where the date of service is totally within the inpatient dates of service at the same or another provider, excluding the date of discharge, are included in the IPPS payment. This provision applies to ambulance services used for the transportation of a hospital inpatient to another facility for diagnostic tests or special treatment.

Pursuant to 42 CFR § 412.2(b)(2) and the Processing Manual, ch. 3, §40, as long as a beneficiary has at least one benefit day at admission, a hospital will receive the basic prospective payment amount. Pursuant to the Benefit Manual, ch. 6, § 10, payment may be made under Part B for nonphysician outpatient services when no Part A prospective payment is made at all for the hospital stay because of patient exhaustion of benefit days before admission.

INCORRECT BILLING

Hospitals incorrectly billed Medicare Part B for 61 of the 127 line items that we reviewed. The incorrectly billed line items were for services provided within 3 days prior to the date of admission for or during (excluding date of discharge) IPPS stays. The incorrect billing resulted in overpayments totaling \$340,073. The majority of the overpayments, 58 sample items totaling \$339,955, were for services provided during IPPS stays. Based on the results of our sample, we estimated that Medicare contractors nationwide made approximately \$6.4 million in overpayments for outpatient nonphysician services. These services included, but were not limited to, laboratory, radiology, and surgical procedures.

CAUSES OF OVERPAYMENTS

Providers attributed incorrect billing to the following factors:

⁶ Effective June 25, 2010 (after our review period), preadmission nondiagnostic services include all outpatient services that are not diagnostic services, ambulance services, or maintenance renal dialysis services that the admitting hospital provides on the date of, or during the 3 days immediately preceding, the admission. Hospitals must bill these services with the inpatient stay, unless they attest that the services are clinically distinct or independent from the reason for the beneficiary's admission. (Preservation of Access to Care for Medicare Beneficiaries and Pension Relief Act of 2010, P.L. No. 111-192 § 102; CMS, *Clarification of Payment Window for Outpatient Services Treated as Inpatient Services*, Pub. 100-20 One-Time Notification, Transmittal 796 (Change Request 7142, October 29, 2010)).

- For 32 of the 61 overpayments totaling \$151,734, incorrect billing was the result of clerical errors during the patient admitting or billing process. For example, one provider stated that it had a manual system that failed to detect incorrect billing.
- For 29 of the 61 overpayments totaling \$188,339, providers were not aware beneficiaries were inpatients at other facilities or did not understand Medicare requirements. For example, one provider stated that it has extensive procedures in place to identify inpatients in its hospital system, but not from outside the system. In addition, some providers did not understand Medicare requirements and billed incorrectly for outpatient services when beneficiaries exhausted their Part A benefits after admission.

In addition, Medicare payment system controls did not prevent or detect overpayments for incorrectly billed services:

- CMS acknowledged Medicare contractors were not aware of incoming CWF alerts because it did not notify Medicare contractors that it had changed the location of this information on the trailer record.
- CMS acknowledged that existing CWF edits did not prevent payments for ambulance services provided during inpatient stays.
- CMS acknowledged that existing CWF edits did not prevent payments for services included in the basic prospective payment rate and furnished after beneficiaries' benefits were exhausted.
- Medicare contractors acknowledged situations where FISS edits were overridden in error or no action was taken on CWF alerts.

RECOMMENDATIONS

We recommend that CMS:

- instruct its Medicare contractors to:
 - recover the \$340,073 in identified overpayments, to the extent allowed under the law, for the 61 incorrectly billed services;
 - work with OIG to resolve the remaining 148,175 services with potential overpayments estimated at approximately \$6.1 million and recover overpayments to the extent allowed under the law;
 - take action to reject claims or recoup overpayments when identified by edits; and

- remind hospitals of the importance of adequate controls to prevent incorrect billing for services provided to beneficiaries within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays;
- communicate with Medicare contractors about changes to the CWF;
- modify existing edits to prevent payments for ambulance services provided during inpatient stays; and
- modify existing edits to prevent payments that are already included in the basic prospective payment rate for nonphysician outpatient services furnished to beneficiaries after the beneficiaries have exhausted their Part A benefits.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS concurred in part with our first recommendation. Specifically, it stated that it would attempt to collect \$284,538 in overpayments from 42 of the 61 billed services that were not outside of the 4-year reopening period for collections and/or below the estimated cost of collection. CMS concurred with the remainder of the first recommendation, the second recommendation, and the fourth recommendation and described its efforts to implement them. CMS stated that it did not concur with our third recommendation as it was stated in the report. CMS verified that the existing alert was working correctly, but acknowledged that the alert listed an incorrect bypass scenario, which deterred the contractor from acting on the alert. CMS stated that it will update the CWF documentation and instructions in the alert to correct the bypass scenario. CMS expects to complete this during fiscal year 2012. CMS's comments are included in their entirety as Appendix D.

We furnished CMS with the information it requested to initiate recovery action.

APPENDIXES

APPENDIX A: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number ¹	Period Covered by Review	Total Overpayments Identified	Issue Date
Millions in Improper Payments to Hospitals for Nonphysician Services Under the Prospective Payment System (A-01-86-62024)	October 1983 through January 1986	\$28.4 million	July 1988
Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-90-00516)	February 1, 1986 through November 30, 1987	\$40 million	August 1990
Nationwide Review of Improper Medicare Payments for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-91-00511)	December 1, 1987 through October 31, 1990	\$38.5 million	Dec. 1992
Expansion of the Diagnosis Related Group Payment Window (A-01-92-00521)	November 1990 through December 1991	\$8.6 million	July 1994
Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-95-00508)	January 1992 through December 1994	\$27 million	May 1996
Follow-up Audit of Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System (A-01-00-00506)	Calendar Years 1997 and 1998	\$5 million	July 2001

¹ These reports are available at <http://oig.hhs.gov>, except for report numbers A-01-86-62024, A-01-90-00516, and A-01-91-00511, which are not available online because of the age of the reports.

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of paid Medicare claims for calendar years 2008 and 2009 for nonphysician outpatient services provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) inpatient prospective payment system (IPPS) stays.

SAMPLING FRAME

The sampling frame was an Access database table that contained 148,302 nonphysician line items of service provided within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays. Those 148,302 line items totaled \$12,015,014 in Medicare Part B payments to providers.

SAMPLE UNIT

The sample unit was a line item of service.

SAMPLE DESIGN

We used a stratified random sample with three strata:

- line items of service with payments less than \$496,
- line items of service with payments of at least \$496 and less than \$20,000, and
- line items of service with payments of \$20,000 or greater.

SAMPLE SIZE

We selected 127 line items: 50 each from strata 1 and 2 and all 27 from stratum 3.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services (OIG/OAS), statistical sampling software, to generate the random numbers for strata 1 and 2.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating the random numbers for each of strata 1 and 2, we selected the corresponding frame items. We selected all 27 frame items from stratum 3.

ESTIMATION METHODOLOGY

We used OIG/OAS statistical software to estimate the overpayments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Overpayments	Value of Overpayments
1	144,128	\$5,570,791	50	\$1,620	15	\$868
2	4,147	5,763,180	50	61,134	34	43,753
3	27	681,043	27	681,043	12	295,452
Total	148,302	\$12,015,014	127	\$743,797	61	\$340,073

Estimates of Overpayments (Limits Calculated for a 90-Percent Confidence Level)

Point Estimate \$6,425,889

Lower Limit \$3,813,325

Upper Limit \$9,038,453



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: MAR 29 2012**TO:** Daniel R. Levinson
Inspector General**FROM:** Marilyn Tavenner
Acting Administrator

A handwritten signature in black ink that reads "Marilyn Tavenner".

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay (A-01-10-00508)

Thank you for the opportunity to review and comment on OIG Draft Report entitled, "Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay" (A-01-10-00508). The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG expended in reviewing this issue. OIG's audit focused on paid Medicare Part B outpatient claims for nonphysician services provided--(1) Within 3 days prior to the date of admission to an Inpatient Prospective Payment System (IPPS) hospital; (2) On the date of admission to an IPPS hospital; and (3) During (excluding date of discharge) an IPPS hospital stay, for calendar years 2008 and 2009. The objective was to determine whether Medicare payments were correct for these nonphysician outpatient claims.

The OIG concluded that providers and Medicare claims administration contractors were not consistently billing or processing outpatient claims for nonphysician services correctly, therefore, requiring education concerning Medicare's Inpatient, Outpatient overlap policies, as well as, the need for adequate controls for processing Common Working File (CWF) edits. OIG also noted that some Medicare contractors were not aware of CWF alerts and their relationship to existing CWF edits that did not prevent payments for services included in the basic prospective payment rate furnished after beneficiaries' Part A benefits were exhausted.

OIG Recommendation 1

The OIG recommends that CMS instruct Medicare contractors to--

- a) Recover the \$340,073 in identified overpayments, to the extent allowed under the law, for the 61 incorrectly billed services;
- b) Work with OIG to resolve the remaining 148,175 services with potential overpayments estimated at approximately \$6.1 million and recover overpayments to the extent allowed under the law;

- c) Take action to reject claims or recoup overpayments when identified by edits; and
- d) Remind hospitals of the importance of adequate controls to prevent incorrect billing for services provided to beneficiaries within 3 days prior to the date of admission for, on the date of admission for, or during (excluding date of discharge) IPPS stays.

CMS Response

- a) The CMS concurs with the recommendation in part. CMS plans to recover the overpayments identified consistent with the agency's policies and procedures. After a preliminary review of the data, CMS will attempt to collect \$284,538 in overpayments from 42 of the 61 billed services. CMS non-concurs with collecting the remaining 19 sampled claims totaling \$55,535 in overpayments because the claims are outside of the 4 year reopening period for collections and/or are below the estimated cost of collection pursuant to 42 CFR 401.621 and 42 CFR 405.376.
- b) The CMS concurs with the recommendation. CMS requests that OIG furnish for each potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, Health Insurance Claim numbers, etc.) to initiate the recovery action. In addition, CMS requests that Medicare contractor-specific data be written to separate CD-ROMs, separate hardcopy worksheets, or sent to CMS electronically using the secure HHS/OIG web portal to better facilitate the transfer of information to the appropriate contractors. Please have OIG staff contact Cami DiGiacomo at (410) 786-5888 to discuss the transfer of this information.
- c) The CMS concurs with the recommendation. In addition, CMS will ensure that contractors are aware of their on-going responsibility to reject claims, and process and recover overpayments when identified by edits. This will be accomplished through contractor education, which is expected to be completed during fiscal year (FY) 2012. CMS will also send educational information to hospitals, reminding them of Medicare's policies on inpatient and outpatient claim overlaps and of their need for adequate controls. This will be accomplished in the form of a Special Edition Medicare Learning Network article, which is expected to be completed during FY 2012.
- d) The CMS concurs with the recommendation. CMS continues in its efforts to inform providers about the payment window policy. In the fall of 2012, CMS plans to issue an update to the Medicare Claims Processing Manual, chapter 3, section 40.3, "Outpatient Services Treated as Inpatient Services." CMS will continue to remind the public as necessary regarding the importance and applicability of the payment window policy. CMS' efforts to inform providers regarding the payment window policy include the following:
- Since the June 25, 2010 enactment of Section 102 of the Preservation of Access to care for Medicare Beneficiaries and Pension Relief Act of 2010 (Pub. L 111-192), which pertain to Medicare's payment window policy, CMS has undertaken various measures to ensure that hospitals and other health care providers are informed and have continuous access to information pertaining to the payment window policy, CMS's efforts have included a variety of regulatory and sub-regulatory documents.

- On August 9, 2010, CMS distributed a memorandum to all hospitals, through their fiscal intermediaries or Medicare administrative contractors, regarding the payment window policy and the requirements of section 102 of Pub. L. 111-192. The memorandum included detailed instructions on appropriate billing for compliance with the law.
- Concurrent with the release of the August 9, 2010 memorandum, CMS posted guidance pertaining to the payment window policy on several of its websites for hospitals and other health care providers (for an example, go to: http://www.cms.gov/AcuteInpatientPPS/08a_Three_Day_Payment_Window.asp#TopOfPage)
- CMS issued an interim final rule with comment period of the FY 2011 Inpatient Prospective Payment System & Long Term Care Hospital Prospective Payment System (IPPS-LTCH PPS) final rule (75 FR 50346, August 16, 2010). In the interim final rule, CMS discussed the payment window policy and adopted changes to the Medicare regulations to comport with the requirements of section 102 of Pub. L. 111-192.
- On October 29, 2010 (in CMS Change Request (CR) # 7142, Transmittal # 796), CMS issued instructions on the use of a new condition code 51 (definition “51 - Attestation of Unrelated Outpatient Non-diagnostic Services”). Starting April 1, 2011, when submitting a claim for outpatient services, hospitals may attest to specific outpatient nondiagnostic services as being unrelated to the hospital claim (that is, the preadmission nondiagnostic services are clinically distinct or independent from the reason for the beneficiary’s admission) by adding a condition code 51 to the claim for the separately billed outpatient nondiagnostic services.
- Throughout the fall and through the winter of 2010, CMS discussed the payment window policy on its monthly Hospitals Open Door Forum calls, in which providers had opportunities to ask questions and have them addressed by the CMS’ payment window policy experts. Providers may still use these forums to ask questions about the payment window policy.
- On May 27, 2011 (in CMS CR # 7443, Transmittal # 2234), CMS issued updated claims processing instructions pertaining to the payment window policy for providers paid under the hospital outpatient prospective payment system.
- In the FY 2012 IPPS-LTCH PPS final rule (76 FR 51705, August 18, 2011), CMS responded to public comments regarding its discussion of the payment window policy in the FY 2011 IPPS-LTCH PPS interim final rule.
- In the calendar year 2012 Physician Fee Schedule final rule (76 FR 73279, November 28, 2011), CMS discussed the applicability of the payment window policy to physician practices that are wholly owned or operated by a hospital, and adopted regulatory changes to comport with the requirements of section 102 of Pub. L. 111-192.
- On December 21, 2011 (in CMS CR # 7502, Transmittal # 2373), CMS issued new claims processing instructions for physician practices that are wholly owned or operated by a hospital. CMS also implemented the new payment modifier PD (“diagnostic or related nondiagnostic item or service provided in a wholly owned or operated entity to a patient who is admitted as an inpatient within 3 days.”) The modifier must be appended to the entity’s preadmission diagnostic and admission-related nondiagnostic services, reported with Contractor Healthcare Common Procedure Coding System/Current Procedural Terminology codes, which are subject to the 3-day payment window policy.

OIG Recommendation 2

The OIG recommends that CMS communicate with Medicare contractors about changes to the CWF.

CMS Response

The CMS concurs with the recommendation and would note that this recommendation has been completed. CWF has an established notification process to notify all contractors on every change they make. This is accomplished by developing a release letter identifying a change and distributing it to the Medicare Shared System Maintainers. Changes also are posted to a website specifically designed to communicate to Medicare contractors any changes to the CWF.

OIG Recommendation 3

The OIG recommends that CMS modify existing edits to prevent payments for ambulance services provided during inpatient stays.

CMS Response

The CMS does not concur with the recommendation, as stated. CMS has verified that the existing alert to prevent payments for ambulance services provided during inpatient stays is working correctly. At the time the contractor received the alert, it listed an incorrect bypass scenario which deterred the contractor from acting on the alert. CMS will update the CWF documentation/instructions in the alert to correct the bypass scenario related to ambulance services. This is expected to be completed during FY 2012.

OIG Recommendation 4

The OIG recommends that CMS modify existing edits to prevent payments that are already included in the basic prospective payment rate for nonphysician outpatient services furnished to beneficiaries after the beneficiaries have exhausted their Part A benefits.

CMS Response

The CMS concurs with the recommendation. CMS is currently examining edits to determine which have already been implemented and are working properly. CMS will then develop instructions for new edits in order to prevent overpayments for non physician outpatient services after the beneficiary has exhausted his/her Part A benefits. A target implementation date for these edits is January 2013.

We appreciate the effort that went into this report and look forward to continuing to work with OIG on safeguarding the Medicare program.