Memorandum

Date MAR 27 2000

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Compliance with the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities (A-01-99-00531)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of our final report on the results of our review of compliance with the consolidated billing provision under the prospective payment system (PPS) for skilled nursing facilities (SNF). Under consolidated billing, a SNF is reimbursed a prospective payment for all covered services rendered to its residents in a Part A stay and outside providers and suppliers must bill the SNF for services rendered. The objectives of our review were to determine: (a) the extent to which providers and suppliers are billing services and Medicare contractors are paying for services in compliance with the consolidated billing requirement, and (b) long-range and interim remedies to prevent and/or reduce overpayments.

We reviewed a judgmental sample of 147 Medicare Part A SNF PPS claims submitted by 18 SNFs and paid by 4 fiscal intermediaries (FI) for dates of service from October 1, 1998 to April 30, 1999. For over one-third of these SNF PPS claims reviewed, we found that Medicare contractors made separate Part B payments to outside suppliers for services which were subject to consolidated billing. These services were included in the PPS payment that Medicare made to the SNF for a covered Part A stay. As a result, the Medicare program is paying twice for the same service--once to the SNF under the Part A prospective payment and again to an outside supplier under Part B. Improper payments to outside providers occurred because Medicare edits have not been established to detect and prevent claims noncompliant with the consolidated billing provision. Also, some suppliers may not be fully cognizant of the consolidated billing provision, and, as a result, improperly billed FIs and carriers.

We discussed our preliminary findings with the Health Care Financing Administration (HCFA) officials. Based on these discussions, HCFA officials were concerned that if our results were indicative of duplicate payment problems nationwide, the impact could be very substantial. In response, they indicated they would prepare a fraud alert and memorandum advising contractors of the duplicate payment problems found in our review and directing them to educate providers with respect to compliance with consolidated billing requirements.

Based on our work to date, we believe that the Medicare program has already made, and will continue to make, significant overpayments until proper controls are established. As a long-term remedy, we recommend that HCFA establish payment edits within its common working file and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision.

We recognize significant resources were being used to ensure HCFA and its contractors would become "Year 2000" compliant and, as such, these efforts delayed system enhancements to detect duplicate billings. Pending the implementation of program edits, we recommend that HCFA adopt these interim remedies:

- Work with the Office of Inspector General in developing a computer application to identify and recover overpayments made to outside suppliers subsequent to the implementation of the consolidated billing provision.

- Issue its proposed fraud alert and memorandum alerting contractors of the prevalent types of payment errors and directing contractors to educate their providers with respect to compliance with the consolidated billing requirement.

- Monitor the Medicare contractors' recovery of the overpayments identified in our review.

The HCFA concurred with our recommendations, and has taken, or agreed to take, corrective action. We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-99-00531 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COMPLIANCE WITH THE CONSOLIDATED BILLING PROVISION UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES

JUNE GIBBS BROWN
Inspector General

MARCH 2000
A-01-99-00531

Memorandum

Date MAR 27 2000

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Compliance with the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities (A-01-99-00531)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our review of compliance with the consolidated billing provision under the prospective payment system (PPS) for skilled nursing facilities (SNF). Under consolidated billing, a SNF is reimbursed a prospective payment for all covered services rendered to its residents in a Part A stay and outside providers and suppliers must bill the SNF for services rendered. The objectives of our review were to determine: (a) the extent to which providers and suppliers are billing services and Medicare contractors are paying for services in compliance with the consolidated billing requirement, and (b) long-range and interim remedies to prevent and/or reduce overpayments.

We reviewed a judgmental sample of 147 Medicare Part A SNF PPS claims submitted by 18 SNFs and paid by 4 fiscal intermediaries (FI) for dates of service from October 1, 1998 to April 30, 1999. For over one-third of these SNF PPS claims reviewed, we found that Medicare contractors made separate Part B payments to outside suppliers for services which were subject to consolidated billing. These services were included in the PPS payment that Medicare made to the SNF for a covered Part A stay. As a result, the Medicare program is paying twice for the same service--once to the SNF under the Part A prospective payment and again to an outside supplier under Part B. Improper payments to outside suppliers occurred because Medicare edits have not been established to detect and prevent claims noncompliant with the consolidated billing provision. Also, some suppliers may not be fully cognizant of the consolidated billing provision, and, as a result, improperly billed FIs and carriers.

Based on our work to date, we believe that the Medicare program has already made, and will continue to make, significant overpayments until proper controls are established. As a long-term remedy, we recommend that the Health Care Financing Administration (HCFA) establish payment edits within its common working file (CWF) and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision.

We recognize significant resources were being used to ensure HCFA and its contractors would become "Year 2000" compliant and, as such, these efforts delayed system enhancements to detect duplicate billings. Pending the implementation of program edits, we recommend that HCFA adopt these interim remedies:

- Work with the Office of Inspector General (OIG) in developing a computer application to identify and recover overpayments made to outside suppliers subsequent to the implementation of the consolidated billing provision.

- Issue its proposed fraud alert and memorandum alerting contractors of the prevalent types of payment errors and directing contractors to educate their providers with respect to compliance with the consolidated billing requirement.

- Monitor the Medicare contractors' recovery of the overpayments identified in our review.

In response to our draft report, HCFA officials concurred with our recommendations. Subsequent to the issuance of our draft report, HCFA has (1) met with the OIG to develop a process to identify and recover the overpayments; and (2) issued a fraud alert on November 19, 1999 alerting Medicare contractors of our findings. Comments from HCFA to our draft report are included in their entirety in the Appendix.

INTRODUCTION

Background

The Balanced Budget Act (BBA) of 1997 requires implementation of a Medicare SNF PPS for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs will no longer be paid in accordance with the reasonable cost-based system but rather through per diem prospective case-mix adjusted payment rates applicable to all covered SNF services. These payment rates cover virtually all costs of furnishing skilled nursing services (that is, routine, ancillary, and capital-related costs). Covered SNF services include post-hospital SNF services for which benefits are provided under Part A and all items and services for which prior to July 1, 1998 payment had been made under Part B but furnished to SNF residents during a Part A covered stay.

The BBA also set forth a consolidated billing requirement applicable to all SNFs providing Medicare services. Under consolidated billing, the SNF is responsible for billing Medicare for virtually all of the services rendered to its residents in a Part A stay. The SNFs will no longer be able to "unbundle" services to an outside provider or supplier that can submit a

separate bill directly to the Medicare Part B carrier. Instead, the SNF must furnish the services either directly or under an arrangement with an outside supplier. The outside supplier will then bill the SNF for the services rendered.

Section 1888(e)(2)(A)(ii) of the Social Security Act excludes certain services from the consolidated billing requirement. These include several types of practitioner services that are exempt and, thus, are still to be billed separately to the Part B carrier. Other services not subject to the consolidated billing provision include dialysis services and supplies, hospice care related to a beneficiary's terminal condition, and ambulance transportation to the SNF for the initial admission or from the SNF following a final discharge. The Balanced Budget Refinement Act of 1999 expanded the list of services excluded from consolidated billing effective April 1, 2000 to include ambulance services furnished in conjunction with dialysis services, certain chemotherapy and radioisotope services, and certain prosthetics.

When a SNF resident receives outpatient services at a hospital, the SNF retains the overall billing responsibility for essentially the entire package of care furnished during the outpatient visit other than the small number of exceptionally intensive services that lie well beyond the scope of care that SNFs would normally furnish, as well as emergency services. Currently, the outpatient hospital services excluded from consolidated billing are cardiac catheterization, CT scans, magnetic resonance imaging, ambulatory surgery, radiation therapy, angiography, lymphatic and venous procedures, and emergency room procedures.

Objectives, Scope, and Methodology

Our review was made in accordance with generally accepted government auditing standards. The objectives of our review were to determine: (a) the extent to which providers and suppliers are billing services and Medicare contractors are reimbursing services in compliance with the consolidated billing provision, and (b) long-range and interim remedies to prevent and/or reduce overpayments. We limited consideration of the internal control structure to the payment controls in place within CWF and selected Medicare contractors' Part A and Part B claims processing systems to ensure compliance with the consolidated billing requirement. The objectives of our review did not require an understanding or assessment of the complete internal control structure at HCFA or its contractors.

To accomplish our objectives, we:

- reviewed applicable Medicare laws and regulations;
- selected for review a judgmental sample of 147 Part A SNF PPS claims paid by 4 FIs for services rendered from October 1, 1998 through April 30, 1999 by 18 SNF providers;

- reviewed CWF Part B, outpatient, and durable medical equipment regional carrier (DMERC) summary records to identify Part B services rendered during the dates of service for the sampled Part A SNF PPS claims;

- reviewed the CWF Part B, outpatient, and DMERC detail claim history to determine whether the FIs or carriers paid providers and suppliers for services for which payment was reimbursed to the SNF through the PPS; and

- discussed our results with HCFA, selected SNFs, and the applicable Medicare FIs and carriers.

The four FIs selected for our review included United HealthCare, Associated Hospital Service of Maine, New Hampshire-Vermont Health Service, and Blue Cross and Blue Shield of Rhode Island. We conducted our review from June 1999 through September 1999 at the OIG regional office located in Boston, Massachusetts.

FINDINGS AND RECOMMENDATIONS

We found that HCFA has not established adequate payment controls to detect and prevent payments made to suppliers which billed for services that are not in compliance with consolidated billing provisions. Based on a judgmental sample of 147 Part A SNF PPS claims paid by 4 FIs, we reviewed applicable Part B payment histories to determine whether Medicare contractors made separate payments to outside suppliers for services which were already reimbursed to the SNFs through the Part A prospective payment. Our review showed that for 50 of 147 SNF PPS claims contractors made separate Part B payments to suppliers for services which are subject to consolidated billing. Specifically, we found that Part B payment histories for:

- Twenty-eight claims included laboratory services for which separate payments were made by carriers to suppliers. Laboratory services are subject to consolidated billing when furnished to a SNF resident, and are included in the PPS payment that Medicare makes to the SNF for a covered Part A stay.

- Sixteen claims included radiology services for which separate payments were made by carriers to outside suppliers for the technical component of the radiology service. Under consolidated billing, when such services are furnished to a SNF resident, only the professional component (interpretation of test) is allowed to be billed separately to the carrier by the physician. The reimbursement of the technical component is included in the SNF PPS rates.

- Eleven claims included outpatient hospital services for which separate payments were made by FIs to the hospitals for non-emergency or non-intensive type services and, thus, were not exempt from consolidated billing.

The SNFs retain the overall billing responsibility for essentially the entire package of care furnished during the outpatient visit other than the small number of exceptionally intensive services that lie well beyond the scope of care that SNFs would normally furnish as well as emergency services.

- Three claims included medical supplies for which separate payments were made by one DMERC to durable medical equipment suppliers. Beginning January 1, 1999, suppliers are no longer allowed to bill the DMERC for medical supplies. These supplies are reimbursed through the SNF PPS rates.

- One claim included ambulance transportation to and from a physician's office for a non-emergency, non-intensive procedure for which separate payments were made by the carrier to the supplier. The consolidated billing provision applies to ambulance transportation that is furnished during the period that the beneficiary is a SNF resident, unless the transportation is to an outpatient hospital for the purpose of receiving excluded emergency or intensive types of services.

These improper payments have occurred because Medicare edits have not yet been established within the CWF and contractors' claims processing systems to detect and prevent claims noncompliant with the consolidated billing provision. Also, some suppliers may not be fully cognizant of the consolidated billing provision, and, as a result, improperly billed FIs and carriers.

The four FIs which processed claims from which we selected our sample used both of the claims processing systems used by FIs nationwide. The carriers associated with Part B claims for our sample used three of the four claims processing systems used by carriers nationwide. We are, therefore, concerned that the Medicare program may be making significant overpayments nationwide for services not in compliance with consolidated billing requirements.

For our judgmental sample of claims totaling 3,186 covered days, the improper Part B payments made to suppliers for services which are subject to consolidated billing are valued at $3,716, or an average overpayment of about $1.17 per day. Although we do not know whether this overpayment per day is representative for all SNF covered days, we believe that the amount of overpayments, nationwide, could be significant. There were about 30.2 million SNF covered days used in the 1995 base period by HCFA for the development of the SNF PPS rates.

We discussed our preliminary findings with HCFA officials. Based on these discussions, HCFA officials were concerned that if our results were indicative of duplicate payment problems nationwide, the impact could be very substantial. In response, they indicated they

would prepare a fraud alert and memorandum advising contractors of the duplicate payment problems found in our review and directing them to educate providers with respect to compliance with consolidated billing requirements.

Recommendations

As a long-term remedy, we recommend that HCFA establish payment edits within the CWF and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision.

We recognize system enhancements to detect duplicate billings were delayed due to the significant resources used to ensure HCFA and its contractors were "Year 2000" compliant. Pending the implementation of program edits, we recommend HCFA adopt these interim remedies:

- Work with the OIG in developing a computer application to identify and recover overpayments made to outside suppliers subsequent to the implementation of the consolidated billing provision.

- Expedite issuance of its proposed fraud alert and memorandum alerting contractors of the prevalent types of payment errors and directing contractors to educate their providers with respect to compliance with the consolidated billing requirement.

- Monitor the Medicare contractors' recovery of the overpayments identified in our review.

HCFA Comments

In its comments to our draft report, HCFA concurred with our recommendations. Specifically, HCFA staff have met with the OIG to develop a process to identify and recover the overpayments. In addition, HCFA agreed to monitor the contractors' recovery of the overpayments identified to date. On November 19, 1999 HCFA issued a fraud alert alerting its Medicare contractors of the OIG's findings. In addition, HCFA is preparing a program memorandum to instruct contractors to educate their providers on the consolidated billing requirements and inform them of the process to recover identified overpayments.

As stated in HCFA's response to our draft report, the overpayments we identified were overpayments made to outside suppliers and not to the SNFs. Our draft report was written in this context and we made revisions to our report to clearly state the overpayments were made to the outside suppliers.

Additional OIG Comments

We are in the process of completing our computer application designed to identify overpayments nationwide. Upon analysis of all prospective overpayment data, we will work with HCFA to determine the best process to convey the data to the respective Medicare contractors for overpayment recovery.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: FEB 2 3 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Review of Compliance with the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities" (A-01-99-00531)

We appreciate the opportunity to comment on the above-referenced report. The OIG report recognizes that HCFA system constraints imposed by Y2K continue to delay system enhancements to detect duplicate billing. The report recommends payment edits within common working file (CWF) and Medicare claims processing systems as a long-term remedy.

The implementation of Skilled Nursing Facilities (SNF) Prospective Payment System (PPS) was a major milestone, along with the many other Balanced Budget Act (BBA) provisions. HCFA is committed to full implementation of the BBA provisions, as amended by the Balanced Budget Refinement Act (BBRA). We are working to establish payment edits within the CWF and Medicare contractors' claims processing systems to ensure compliance and program integrity with the SNF consolidated billing provision, but as acknowledged by OIG, have been delayed due to Y2K preparations.

We note that what the report characterizes as an "overpayment" does not represent an overpayment to the SNF itself, to which Part A has appropriately made a global per diem payment under the SNF PPS for a comprehensive package of institutional care that includes the services in question. Rather, the inappropriate payment in this situation is the one that Part B makes to the outside supplier of the services, which is the appropriate entity toward which to direct any recovery actions. In this context, HCFA understands the importance of systems edits to identify billing of Part B services that are included in the PPS rates.

We concur with the OIG's recommendations. Our detailed comments are attached.

Attachment

Attachment

OIG Recommendation
HCFA should work with the OIG in developing computer applications to identify and recover overpayments made subsequent to the implementation of the consolidated billing provision.

HCFA Response
We concur. HCFA staff have met with the OIG staff to develop a process to identify and recover the overpayments. The OIG is developing a computer application which will expand its prior review to identify duplicate billing overpayments nationwide. HCFA will then direct its contractors to recover the identified overpayments. We are exploring the workload and budget impacts associated with implementing this process and may consider conducting a pilot test in one region.

OIG Recommendation
HCFA should expedite issuance of its proposed fraud alert and memorandum alerting contractors of the prevalent types of payment errors and directing contractors to educate their providers with respect to compliance with the consolidated billing requirement.

HCFA Response
We concur. HCFA issued a fraud alert on November 19, 1999 alerting contractors of the OIG's findings. A program memorandum is being prepared to instruct contractors to educate their providers on the consolidated billing requirements and inform them of the process to recover identified overpayments.

OIG Recommendation
HCFA should monitor the Medicare contractors' recovery of the overpayments identified in our review.

HCFA Response
We concur. We will monitor the Medicare contractors' recovery of the overpayments identified.

Technical Comment
On page 3, after the discussion of the BBA, it should be noted that the BBRA expanded the list of services excluded from consolidated billing to include ambulance services when provided in conjunction with dialysis services, certain chemotherapy services, certain radioisotope services, and certain prosthetics.