



JAN 30 2008

**TO:** Kerry Weems  
Acting Administrator  
Centers for Medicare & Medicaid Services

**FROM:** Daniel R. Levinson *Daniel R. Levinson*  
Inspector General

**SUBJECT:** Payments for Outpatient Hospital, Laboratory, and Radiology Services Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A (A-01-06-00503)

The attached final report provides the results of our review of payments for outpatient hospital, laboratory, and radiology services made on behalf of beneficiaries in skilled nursing facility (SNF) stays covered under Medicare Part A.

Under the prospective payment system, most outpatient hospital services and the technical component of laboratory and radiology services are included in the SNFs' Medicare Part A payments. Therefore, Medicare Part B payments that suppliers receive for such services are overpayments.

To prevent Part B overpayments to suppliers for services provided to beneficiaries in Part A-covered SNF stays, the Centers for Medicare & Medicaid Services (CMS) began implementing computerized edits in its Common Working File in calendar year (CY) 2002. The edits for both carriers and fiscal intermediaries were fully operational in CY 2003. When SNFs submit their claims before suppliers submit theirs, prepayment edits are designed to identify and deny payments for inappropriately billed Part B services before CMS reimburses the suppliers. When SNFs submit their claims after suppliers submit theirs, postpayment edits are designed to identify Part B overpayments after CMS has reimbursed the suppliers. Overpayments identified on a postpayment basis must be recovered through offset or collection activities.

The objectives of our review were to determine (1) the amount of potential Medicare overpayments to suppliers of outpatient hospital, laboratory, and radiology services for CYs 2001 and 2002, before the Common Working File edits were fully operational, and (2) the amount of unrecovered overpayments for CY 2003, after the edits were fully operational.

For CYs 2001 and 2002, Medicare Part B made a total of \$106.9 million in potential overpayments to suppliers of outpatient hospital, laboratory, and radiology services on behalf of

beneficiaries in Part A-covered SNF stays. These potential overpayments occurred because CMS did not have Common Working File edits in place during most of this period. As a result, fiscal intermediaries and carriers may have been unable to identify the potential overpayments and initiate recovery actions.

For CY 2003, when the edits were fully implemented, potential overpayments were reduced to \$22.7 million. We estimated that the fiscal intermediaries and carriers had not recovered \$17.9 million of these potential overpayments. Unrecovered overpayments continued to occur because (1) the edits did not identify all overpayments or (2) the edits identified the overpayments, but contractors experienced claim-processing system problems, misunderstood recovery instructions, or made errors during the recovery process.

We recommend that CMS:

- direct the fiscal intermediaries and carriers to review the \$106.9 million in potential overpayments for CYs 2001 and 2002 and make appropriate recoveries,
- direct the fiscal intermediaries and carriers to initiate recovery of the estimated \$17.9 million in unrecovered overpayments for CY 2003,
- continue to test and refine the Common Working File edits to ensure that they properly identify claims subject to consolidated billing, and
- ensure that all fiscal intermediaries and carriers have established proper controls to recover overpayments that the Common Working File edits identify.

In its comments on our draft report, CMS agreed with the recommendations.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after this report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov). Please refer to report number A-01-06-00503 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PAYMENTS FOR OUTPATIENT  
HOSPITAL, LABORATORY, AND  
RADIOLOGY SERVICES MADE ON  
BEHALF OF BENEFICIARIES IN  
SKILLED NURSING FACILITY  
STAYS COVERED UNDER  
MEDICARE PART A**



Daniel R. Levinson  
Inspector General

January 2008  
A-01-06-00503

# ***Office of Inspector General***

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

## **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**

Section 1888(e) of the Social Security Act (the Act) established a Medicare prospective payment system for skilled nursing facilities (SNF). Under the prospective payment system, most outpatient hospital services and the technical component of laboratory and radiology services are included in the SNFs' Medicare Part A payments. Accordingly, under the Act's consolidated billing provisions, SNFs are responsible for billing Medicare Part A for these services, and suppliers are responsible for billing the SNFs. Therefore, Medicare Part B payments that suppliers receive for these services are overpayments.

To prevent Part B overpayments to suppliers for services provided to beneficiaries in Part A-covered SNF stays, the Centers for Medicare & Medicaid Services (CMS) began implementing computerized edits in its Common Working File in calendar year (CY) 2002. The edits for both carriers and fiscal intermediaries were fully operational in CY 2003. When SNFs submit their claims before suppliers submit theirs, prepayment edits are designed to identify and deny payments for inappropriately billed Part B services before CMS reimburses the suppliers. When SNFs submit their claims after suppliers submit theirs, postpayment edits are designed to identify Part B overpayments after CMS has reimbursed the suppliers. Overpayments identified on a postpayment basis must be recovered through offset or collection activities.

### **OBJECTIVES**

The objectives of our review were to determine (1) the amount of potential Medicare overpayments to suppliers of outpatient hospital, laboratory, and radiology services for CYs 2001 and 2002, before the Common Working File edits were fully operational, and (2) the amount of unrecovered overpayments for CY 2003, after the edits were fully operational.

### **SUMMARY OF FINDINGS**

For CYs 2001 and 2002, Medicare Part B made a total of \$106.9 million in potential overpayments to suppliers of outpatient hospital, laboratory, and radiology services on behalf of beneficiaries in Part A-covered SNF stays. These potential overpayments occurred because CMS did not have Common Working File edits in place during most of this period. As a result, fiscal intermediaries and carriers may have been unable to identify the potential overpayments and initiate recovery actions.

For CY 2003, when the edits were fully implemented, potential overpayments were reduced to \$22.7 million. We estimated that the fiscal intermediaries and carriers had not recovered \$17.9 million of these potential overpayments. Unrecovered overpayments continued to occur because (1) the edits did not identify all overpayments or (2) the edits identified the overpayments, but contractors experienced claim-processing system problems, misunderstood recovery instructions, or made errors during the recovery process.

## **RECOMMENDATIONS**

We recommend that CMS:

- direct the fiscal intermediaries and carriers to review the \$106.9 million in potential overpayments for CYs 2001 and 2002 and make appropriate recoveries,
- direct the fiscal intermediaries and carriers to initiate recovery of the estimated \$17.9 million in unrecovered overpayments for CY 2003,
- continue to test and refine the Common Working File edits to ensure that they properly identify claims subject to consolidated billing, and
- ensure that all fiscal intermediaries and carriers have established proper controls to recover overpayments that the Common Working File edits identify.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments on our draft report, CMS agreed with the recommendations. We have included CMS's comments as Appendix E.

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## INTRODUCTION

### BACKGROUND

#### **Skilled Nursing Facility Prospective Payment System and Consolidated Billing**

Section 1888(e) of the Social Security Act (the Act) established a Medicare prospective payment system for skilled nursing facilities (SNF) for cost-reporting periods beginning on or after July 1, 1998. Under the prospective payment system, Medicare Part A pays SNFs through per diem, prospective, case-mix-adjusted payment rates that cover virtually all of their costs for furnishing services to Medicare beneficiaries. Accordingly, under the consolidated billing provisions of sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most of the services provided to Medicare beneficiaries in SNF stays covered under Medicare Part A, including services that outside suppliers provide under arrangement. The outside suppliers must then bill the SNFs for these services.

#### **Outpatient Hospital, Laboratory, and Radiology Services Furnished to Skilled Nursing Facility Residents**

Specific types of outpatient hospital services that are so exceptionally intensive, costly, or emergent that they fall well outside the typical scope of SNF care plans are excluded from consolidated billing. Instead of billing the SNFs, the suppliers of these services bill Medicare Part B.<sup>1</sup> For laboratory and radiology services provided to SNF residents, Medicare Part B covers only the professional component (interpretation). Medicare Part A reimburses SNFs for the technical component as part of the prospective payment, and the suppliers bill the SNFs for these services. Thus, Medicare Part B payments to suppliers of the technical component of laboratory and radiology services, as well as suppliers of most outpatient hospital services, are overpayments.

#### **Medicare Fiscal Intermediaries and Carriers**

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries and carriers to process and pay Medicare claims. Fiscal intermediaries are responsible for processing Parts A and B claims from facilities, including hospitals, SNFs, rural health clinics, and federally qualified health centers. Carriers are responsible for processing Part B claims from suppliers, including those that perform the professional component of laboratory and radiology services.

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<sup>1</sup>Services excluded from SNF consolidated billing include cardiac catheterization, computerized axial tomography scans, magnetic resonance imaging, ambulatory surgery that involves the use of an operating room, emergency services, radiation therapy services, angiography, and certain lymphatic and venous procedures. A complete list of excluded services can be found at [http://www.cms.hhs.gov/SNFPPS/05\\_ConsolidatedBilling.asp](http://www.cms.hhs.gov/SNFPPS/05_ConsolidatedBilling.asp). Accessed on September 12, 2007.

## **System Edits To Detect Overpayments**

To prevent Part B overpayments made on behalf of beneficiaries in Part A-covered SNF stays, CMS began implementing computerized edits in its Common Working File in calendar year (CY) 2002. For claims processed by Medicare carriers, CMS implemented prepayment edits in April 2002 and postpayment edits in July 2002. For claims processed by fiscal intermediaries, CMS implemented both edits in January 2003. When SNFs submit their claims before suppliers submit theirs, prepayment edits are designed to identify and deny payments for inappropriately billed Part B services before CMS reimburses the suppliers. When SNFs submit their claims after suppliers submit theirs, postpayment edits are designed to identify Part B overpayments after CMS has reimbursed the suppliers. Overpayments identified on a postpayment basis must be recovered through offset or collection activities.

## **Prior Office of Inspector General Reports**

In a June 2007 report (A-01-05-00511), we identified \$112 million in unrecovered potential Part B overpayments to suppliers of durable medical equipment, prosthetics, orthotics, and supplies made on behalf of beneficiaries in Part A-covered SNF stays during CYs 1999–2003. Several earlier reports identified a total of \$194.5 million in Medicare Part B overpayments made on behalf of beneficiaries during Part A-covered SNF stays for various audit periods during CYs 1998–2000. (See Appendix A.)

## **OBJECTIVES, SCOPE, AND METHODOLOGY**

### **Objectives**

The objectives of our review were to determine (1) the amount of potential Medicare overpayments to suppliers of outpatient hospital, laboratory, and radiology services for CYs 2001 and 2002, before the Common Working File edits were fully operational, and (2) the amount of unrecovered overpayments for CY 2003, after the edits were fully operational.

### **Scope**

We identified and reviewed nationwide potential overpayments that Medicare fiscal intermediaries and carriers made to suppliers of outpatient hospital, laboratory, and radiology services for claims with dates of service in CYs 2001–2003.

Our objectives did not require an understanding or assessment of the complete internal control structure at CMS, the fiscal intermediaries and carriers, or the suppliers. We limited consideration of the internal control structure to the payment controls in place within the Common Working File and in the claim-processing systems of selected fiscal intermediaries and carriers. We did not assess the completeness of data extracted from CMS's National Claims History file.

We performed fieldwork at a carrier in Connecticut and a laboratory in New Jersey between May and October 2006.

## Methodology

To accomplish our objectives:

- We reviewed applicable laws, regulations, and Medicare program guidance.
- Using data from CMS's National Claims History file, we performed a nationwide computer match to determine the amount of potential Medicare overpayments to suppliers for CYs 2001–2003. We matched SNF stays covered under Medicare Part A to Part B outpatient hospital, laboratory, and radiology services provided to SNF residents during those years. Recoveries made after March 2004 are not reflected in the data used to perform our computer match. (See Appendix B for a description of our computer match methodology.)
- We used the results of the computer match for CYs 2001 and 2002 to determine potential overpayments made before the edits were fully implemented. We used the results of the computer match for CY 2003 to determine potential overpayments made after the edits were fully implemented.
- For CY 2003, we identified a population of 300,183 beneficiary days on which Medicare made 321,114 potential overpayments of \$20 to \$2,500 per beneficiary day. From this population, we selected a stratified statistical sample of 100 beneficiary days containing 117 potential overpayments. We used the statistical sample to validate the results of the computer match and estimate the amount of unrecovered overpayments for CY 2003.
- We also reviewed all 50 of the CY 2003 beneficiary days on which Medicare payments exceeded \$2,500 per beneficiary day. The 50 beneficiary days contained 53 potential overpayments.
- We reviewed available data from the Common Working File for the 150 beneficiary days and for the corresponding 150 SNF claims to validate the results of our computer match for CY 2003.
- We contacted representatives from 122 of the 128 suppliers that billed for the 150 beneficiary days to confirm the CY 2003 overpayments.<sup>2</sup> We also validated the 170 potential overpayments associated with the 150 beneficiary days by contacting the 14 Medicare fiscal intermediaries and 12 carriers that made the payments.
- We obtained an understanding of selected fiscal intermediaries' and carriers' policies and procedures for resolving overpayments that the Common Working File edits identified.

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<sup>2</sup>Of the remaining six suppliers, four were no longer in the Medicare program, and two were under investigation by the Office of Inspector General.

- We reviewed the fiscal intermediaries' and carriers' documentation to determine whether the edits had identified the overpayments in the 150 beneficiary days and whether the contractors had recovered the overpayments.
- We used a stratified variable appraisal program to estimate the dollar value of nationwide CY 2003 potential overpayments to suppliers that the fiscal intermediaries and carriers had not recovered. We used a stratified attribute appraisal program to estimate the number of CY 2003 beneficiary days that contained overpayments that had not been recovered.

See Appendix C for a description of our sampling methodology and Appendix D for our sample results and estimates.

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 objectives.

## **FINDINGS AND RECOMMENDATIONS**

For CYs 2001 and 2002, Medicare Part B made a total of \$106.9 million in potential overpayments to suppliers of outpatient hospital, laboratory, and radiology services on behalf of beneficiaries in Part A-covered SNF stays. These potential overpayments occurred because CMS did not have Common Working File edits in place during most of this period. As a result, fiscal intermediaries and carriers may have been unable to identify the potential overpayments and initiate recovery actions.<sup>3</sup>

For CY 2003, when the edits were fully implemented, potential overpayments were reduced to \$22.7 million. We estimated that the fiscal intermediaries and carriers had not recovered \$17.9 million of these potential overpayments. Unrecovered overpayments continued to occur because (1) the edits did not identify all overpayments or (2) the edits identified the overpayments, but contractors experienced claim-processing system problems, misunderstood recovery instructions, or made errors during the recovery process.

## **PROGRAM REQUIREMENTS**

The "Medicare Claims Processing Manual," Publication 100-04, Chapter 6, section 110.2.1, and CMS Program Memorandum, Transmittal AB-02-023, provide that when edits identify an overpayment after the supplier has been paid, the Common Working File electronically transmits a notice (called an unsolicited response) to the fiscal intermediary or carrier that originally processed the payment. When the fiscal intermediary or carrier receives an unsolicited response,

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<sup>3</sup>Carriers may have recovered some laboratory and radiology overpayments after CMS implemented postpayment edits in July 2002. We did not sample from CY 2002 because the new edits created significant backlogs for some carriers early in the implementation period.

it must initiate an adjustment to deny the original payment and follow requirements for recovering the overpayment.

The Federal Claims Collection Act of 1966 (31 U.S.C. § 3711), as implemented by 31 CFR § 901.1, requires timely and aggressive efforts to recover overpayments, including efforts to locate the debtor when necessary, issue demands for repayment, and effect recoupment. CMS regulations (42 CFR §§ 405.370–405.378) specify the Medicare contractors' responsibilities with respect to overpayments and debt, including issuance of written demand letters, assessment of interest, and recoupment. CMS's "Medicare Financial Management Manual" also provides guidance on recovering overpayments.

## **POTENTIAL OVERPAYMENTS FOR CALENDAR YEARS 2001 AND 2002**

For CYs 2001 and 2002, our computer match identified potential Part B overpayments to suppliers totaling \$106.9 million: \$62.9 million made by fiscal intermediaries to outpatient hospitals, rural health clinics, and federally qualified health centers and \$44 million made by carriers to laboratory and radiology suppliers. These potential overpayments occurred because CMS did not fully implement the Common Working File edits to prevent and detect Part B payments on behalf of beneficiaries in Part A-covered SNF stays until July 2002 for carriers and January 2003 for fiscal intermediaries. Before the edits were fully implemented, the contractors may have been unable to identify potential overpayments and initiate recovery actions.

## **RECOVERY OF OVERPAYMENTS FOR CALENDAR YEAR 2003**

For CY 2003, our computer match identified \$22.7 million in potential Part B overpayments, a 58-percent average reduction since CYs 2001 and 2002. Based on the results of our statistical sample and our additional review of all beneficiary days on which payments exceeded \$2,500, we estimated that the contractors had not recovered a total of \$17.9 million of these potential overpayments at the start of our audit in April 2006. The fiscal intermediaries were responsible for recovering \$14.9 million of this total from outpatient hospitals, rural health clinics, and federally qualified health centers, and the carriers were responsible for recovering \$3 million from laboratory and radiology suppliers.

Our specific results follow:

- For payments of \$20 to \$2,500 per beneficiary day, the contractors had not recovered 65 of the 117 potential overpayments included in our statistical sample. We estimated that these unrecovered overpayments totaled \$17.6 million and represented 64 percent of the beneficiary days that our computer match identified.
- For payments exceeding \$2,500 per beneficiary day, the contractors had not recovered 29 of the 53 potential overpayments. These unrecovered overpayments totaled \$331,072.

The fiscal intermediaries and carriers did not collect some of these overpayments because the Common Working File edits did not identify all overpayments. The fiscal intermediaries did not collect some of the overpayments that the edits identified because the Medicare claim-processing

systems did not create an automated adjustment to initiate recovery. The carriers told us that their reasons for not collecting some of the identified overpayments included misunderstanding CMS's recovery instructions and making errors during the recovery process.

We expect that Part B overpayments to suppliers will be significantly reduced following CY 2003. After our audit period, CMS addressed edit implementation issues that its contractors had identified. Furthermore, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 excluded services provided by rural health clinics and federally qualified health centers from SNF consolidated billing as of January 1, 2005. These services represented about 25 percent of the sampled overpayments made by fiscal intermediaries.

## **RECOMMENDATIONS**

We recommend that CMS:

- direct the fiscal intermediaries and carriers to review the \$106.9 million in potential overpayments for CYs 2001 and 2002 and make appropriate recoveries,
- direct the fiscal intermediaries and carriers to initiate recovery of the estimated \$17.9 million in unrecovered overpayments for CY 2003,
- continue to test and refine the Common Working File edits to ensure that they properly identify claims subject to consolidated billing, and
- ensure that fiscal intermediaries and carriers have established proper controls to recover overpayments that the Common Working File edits identify.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments on our draft report, CMS agreed with the recommendations. CMS stated that it would recover the overpayments consistent with its policies and procedures and requested that we furnish the data necessary to review claims and recover the overpayments. CMS also provided information on actions taken or planned to ensure that the Common Working File edits are working properly and that its contractors have established proper controls to recover overpayments that the Common Working File edits identify. We have included CMS's comments as Appendix E.

As CMS requested, we provided the data necessary to initiate its review and recovery effort.

# **APPENDIXES**

**PREVIOUS OFFICE OF INSPECTOR GENERAL REPORTS ON  
MEDICARE PART B PAYMENTS MADE ON BEHALF OF BENEFICIARIES  
DURING PART A SKILLED NURSING FACILITY STAYS**

Report Title and Number <sup>1</sup>	Period Covered by Review	Outpatient Hospital, Laboratory, and Radiology Overpayments Identified	Total Overpayments Identified	Issue Date
“Review of Compliance With the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities” (A-01-99-00531)	10/1/1998– 4/30/1999	Not applicable	\$0	March 27, 2000
“Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System” (A-01-00-00538)	Calendar year (CY) 1999	\$31.1 million	\$47.6 million <sup>2</sup>	June 5, 2001
“Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities” (A-01-00-00509)	CYs 1996–1998	Not applicable	\$35 million	July 23, 2001
“Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities for Time Periods Between the Full Month Periods Covered by Our Prior Report and the Date of Discharge From the Skilled Nursing Facility” (A-01-01-00513)	CYs 1996–1998	Not applicable	\$10.5 million	October 17, 2001
“Review of Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System in Calendar Years 1999 and 2000” (A-01-02-00513)	CYs 1999–2000	\$77.4 million	\$108.3 million	May 28, 2004
“Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A” (A-01-05-00511)	CYs 1999–2003	Not applicable	\$112 million	June 26, 2007

<sup>1</sup>With the exception of report number A-01-01-00513, these reports are available at <http://oig.hhs.gov>. Report number A-01-01-00513 was issued as an addendum to report number A-01-00-00509.

<sup>2</sup>As noted in report number A-01-02-00513, we reduced the \$47.6 million to \$40.7 million to account for improper payments refunded by suppliers after this review, as well as refinements in our matching methodology.



## **COMPUTER MATCH METHODOLOGY TO IDENTIFY POTENTIAL OVERPAYMENTS**

### **SKILLED NURSING FACILITY DATA**

To identify potential overpayments, we:

- extracted claim information from the National Claims History file for CYs 2001–2003;
- limited the population to claims with revenue center code 0022, denoting a prospective payment;
- eliminated claims involving hospital swing beds (type of bill 18X);
- eliminated claims for managed care organization enrollees (condition code 04); and
- sorted claims by beneficiary and admission date and grouped the sorted claims together to identify skilled nursing facility (SNF) stays.

### **OUTPATIENT DATA**

To identify potential overpayments, we:

- extracted paid claim information from the National Claims History file for CYs 2001–2003 based on beneficiaries' health insurance claim numbers from the SNF paid claim data;
- eliminated claims with Healthcare Common Procedure Coding System (HCPCS) codes indicating at least one service that the Centers for Medicare & Medicaid Services (CMS) excludes from consolidated billing;
- eliminated claims with emergency room revenue center codes 0450–0459;
- eliminated end stage renal disease (ESRD) claims, as identified with revenue center codes 0820–0859;
- eliminated dialysis-related erythropoietin claims, as identified with revenue center codes 0634 and 0635 and a primary diagnosis code of renal disease;
- eliminated claims with Medicare preventive and screening services, as identified by HCPCS codes in CMS program guidance;
- eliminated claims with \$0 Medicare payment, \$0 coinsurance, and \$0 deductible;
- eliminated claims for services provided during the noncovered portion of the SNF stay;

- eliminated claims for ambulance services, as identified by revenue center codes 0540–0549;
- eliminated claims for cast room services, as identified by revenue center codes 0700 and 0709;
- eliminated lines of service with “from” dates of service on or before the SNF stay admission date; and
- eliminated lines of service with “from” dates of service on or after the SNF stay discharge date.

## **LABORATORY AND RADIOLOGY DATA**

To identify potential overpayments, we:

- extracted paid claim information from the National Claims History file for CYs 2001–2003 based on beneficiaries’ health insurance claim numbers from the SNF paid claim data;
- eliminated services with a “26” HCPCS modifier, indicating a professional component;
- eliminated services that matched an outpatient ESRD claim (laboratory only);
- eliminated services that contained a “CB” HCPCS modifier, indicating services related to dialysis treatment for ESRD;
- eliminated dialysis-related services accompanied by a primary diagnosis code of renal disease;
- eliminated emergency room services, as identified by place of service code 23;
- eliminated Medicare preventive services, as identified by HCPCS codes in CMS program guidance;
- eliminated claims for services provided during the noncovered portion of the SNF stay;
- eliminated services with \$0 Medicare payment, \$0 coinsurance, and \$0 deductible;
- eliminated services with physician involvement, as identified by the professional component/technical component indicator field of the National Physician Fee Schedule Relative Value File;
- eliminated globally billed services before April 1, 2001;
- eliminated services provided on the day of SNF admission or discharge; and

- eliminated claims for radioisotope services, chemotherapy, and customized prosthetic devices for dates of services on or after April 1, 2000, as identified by HCPCS codes in CMS program guidance.

## SAMPLING METHODOLOGY

### OBJECTIVE

Our sampling objective was to determine the amount of CY 2003 overpayments for outpatient hospital, laboratory, and radiology services that the fiscal intermediaries and carriers had not recovered.

### POPULATION

The population consisted of beneficiary days that included potential CY 2003 overpayments for outpatient hospital, laboratory, and radiology services made on behalf of beneficiaries in Part A SNF stays.

<b>Population Characteristics</b>			
<b>Stratum</b>	<b>Number of Beneficiary Days</b>	<b>Number of Potential Overpayments</b>	<b>Paid Amount of Potential Overpayments</b>
<b>\$20–\$2,500 Billed per Beneficiary Day</b>			
Outpatient hospital	164,730	158,347	\$15,013,199
Laboratory	81,855	108,123	3,891,612
Radiology	53,598	54,644	3,419,796
<b>Subtotal</b>	<b>300,183</b>	<b>321,114</b>	<b>\$22,324,607</b>
<b>More Than \$2,500 Billed per Beneficiary Day</b>			
Outpatient hospital	41	35	\$394,615
Laboratory	2	5	3,660
Radiology	7	13	16,835
<b>Subtotal</b>	<b>50</b>	<b>53</b>	<b>\$415,110</b>
<b>Total</b>	<b>300,233</b>	<b>321,167</b>	<b>\$22,739,717</b>

### SAMPLE DESIGN

The audit used a stratified random sample design. Our sampling frame included beneficiary days containing outpatient hospital, laboratory, and radiology services for which Medicare paid between \$20 and \$2,500 for a given beneficiary day. Additionally, we reviewed all of the beneficiary days for which Medicare payments exceeded \$2,500 each.

We defined an error as an overpayment that was not recovered by a fiscal intermediary or carrier.

**SAMPLE SIZE**

The statistical sample consisted of 100 beneficiary days: 40 from the outpatient hospital stratum, 30 from the laboratory stratum, and 30 from the radiology stratum. These 100 beneficiary days contained 117 potential overpayments.

Our additional review of all 50 beneficiary days for which Medicare payments exceeded \$2,500 consisted of 41 beneficiary days from the outpatient hospital stratum, 2 from the laboratory stratum, and 7 from the radiology stratum. These 50 beneficiary days contained 53 potential overpayments.

## SAMPLE RESULTS AND ESTIMATES

### SAMPLE AND ADDITIONAL REVIEW RESULTS

Our review of a statistical sample of 100 beneficiary days containing 117 potential overpayments for CY 2003 found that 65 of the potential overpayments had not been recovered when we began our audit. Our additional review of all 50 beneficiary days with more than \$2,500 billed per beneficiary day for CY 2003 found that 29 of the 53 potential overpayments had not been recovered when we began our audit.

#### Sample Results: \$20–\$2,500 Billed per Beneficiary Day

Stratum	Sample Size		Paid Amount of Sample	Number of Potential Overpayments Not Recovered		Paid Amounts Not Recovered
	Beneficiary Days	Potential Overpayments		Beneficiary Days	Potential Overpayments	
Outpatient						
hospital	40	41	\$3,928	33	34	\$3,536
Laboratory	30	46	2,492	13	20	775
Radiology	30	30	2,117	11	11	510
<b>Total</b>	<b>100</b>	<b>117</b>	<b>\$8,537</b>	<b>57</b>	<b>65</b>	<b>\$4,821</b>

#### Additional Review Results: More Than \$2,500 Billed per Beneficiary Day

Stratum	Sample Size		Paid Amount of Sample	Number of Potential Overpayments Not Recovered		Paid Amounts Not Recovered
	Beneficiary Days	Potential Overpayments		Beneficiary Days	Potential Overpayments	
Outpatient						
hospital	41	35	\$394,615	35	29	\$331,072
Laboratory	2	5	3,660	0	0	0
Radiology	7	13	16,835	0	0	0
<b>Total</b>	<b>50</b>	<b>53</b>	<b>\$415,110</b>	<b>35</b>	<b>29</b>	<b>\$331,072</b>

### VARIABLE ESTIMATE

The point estimate of the unrecovered overpayments based on our statistical sample was \$17,590,582 with a precision of plus or minus \$4,869,970 at the 90-percent confidence level.

With the addition of the \$331,072 in unrecovered overpayments from our additional review of all beneficiary days for which Medicare payments exceeded \$2,500, unrecovered overpayments for CY 2003 totaled \$17,921,654.

**ATTRIBUTE ESTIMATE**

For CY 2003, we estimated that 191,025 (64 percent) of the 300,183 beneficiary days that our computer match identified contained overpayments that had not been recovered when we began our audit. At the 90-percent confidence level, the precision of this estimate was plus or minus 7.35 percent.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator  
Washington, DC 20201

2007 DEC 4 AM 8:19  
OFFICE OF INSPECTOR GENERAL

RECEIVED

DATE: NOV 30 2007

FROM: Kerry Weems  
Acting Administrator

TO: Daniel R. Levinson  
Inspector General

SUBJECT: Office of Inspector General (OIG) Draft Report: "Payments for Outpatient Hospital, Laboratory and Radiology Services Made on Behalf of Beneficiaries in Skilled Facility Stays Covered Under Medicare Part A" (A-01-06-00503)

Thank you for the opportunity to review and comment on this draft report, "Payments for Outpatient Hospital, Laboratory and Radiology Services Made on Behalf of Beneficiaries in Skilled Nursing Facilities (SNFs) under Medicare Part A. The Centers for Medicare & Medicaid Services (CMS) appreciates the effort OIG has invested in this report.

Under the SNF prospective payment system, outpatient hospital, laboratory, and radiology services furnished during a beneficiary's SNF stay are generally included in the SNF's Medicare Part A payments. Thus, Medicare Part B payments to suppliers for such items are considered overpayments. In this draft report, OIG identified potential Medicare overpayments for claims from calendar years (CYs) 2001-2003.

The CMS is committed to improving its efforts to reduce improper Medicare claims payments and to actively pursue recoveries of improper payments. We thank the OIG for its efforts on this report and look forward to their continued support as we address the report recommendations. Our response to the recommendations and technical comments on the report follow.

**OIG Recommendation**

Continue to test and refine the Common Working File edits to ensure that they properly identify claims subject to consolidated billing.



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**CMS Response**

The CMS will modify the statement of work of the Single Testing Contractor (STC) to have a representative sample of situations tested to ensure the Common Working File (CWF) consolidated billing edits are working properly. CMS will also review the existing CWF edit routines to ensure they are capturing all of the codes that should be included in the consolidated billing rules.

**OIG Recommendation**

Ensure that all fiscal intermediaries and carriers have established proper controls to recover overpayments that the Common Working File edits identify.

**CMS Response**

The CMS currently works with Medicare contractors to ensure that payments are made accurately and to make appropriate recoveries in accordance with the Agency's policies and procedures. CMS has issued instructions to the Medicare contractors to recover overpayments related to unsolicited CWF responses for SNF claims. Furthermore, fiscal intermediaries and carriers continue to process all unsolicited responses under the current contract. CMS reviews and monitors the Medicare contractor performance for these areas on an ongoing basis.

**OIG Recommendation**

The CMS should direct the fiscal intermediaries and carriers to review the \$106.9 million in potential overpayments for CYs 2001 and 2002 and make appropriate recoveries.

**CMS Response**

The CMS agrees with the OIG recommendation that CMS direct the fiscal intermediaries and carriers to review the claims processed and to initiate appropriate recoveries of potential overpayments. The CMS will recover the overpayments consistent with the Agency's policies and procedures. The CMS requests that OIG provide the data necessary (e.g., provider numbers, claims information including the paid date, HIC numbers, etc.) to help us determine which claims are within the reopening period. We also ask that Medicare contractor-specific data be written to separate compact disks in order to better facilitate the transfer of information to the appropriate contractors.

**OIG Recommendation**

The CMS should direct the fiscal intermediaries and carriers to initiate recovery of the estimated \$17.9 million in unrecovered overpayments for CY 2003.

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**CMS Response**

The CMS agrees that the overpayments identified from a review of the claims in question should be recovered. However, CMS will recover the overpayments consistent with the Agency's policies and procedures. As mentioned earlier, CMS requests that OIG furnish for each overpayment the data necessary (e.g., provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, we ask that Medicare contractor-specific data be written to separate compact disks in order to better facilitate the transfer of information to the appropriate contractors.