DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date AUG 29 1995

From June Gibbs Brown
Inspector General

Subject Status Report - Office of Inspector General/Department of Justice Joint Project--Medicare Nonphysician Outpatient Bills Submitted by Hospitals (A-03-94-00021)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached is a copy of our report entitled "Status Report - Office of Inspector General/Department of Justice Joint Project--Medicare Nonphysician Outpatient Bills Submitted by Hospitals." The primary objectives of this joint Office of Inspector General (OIG)/Department of Justice (DOJ) project are to: (1) recover from hospitals, previously identified by the OIG as billing for outpatient services that were included in the inpatient payment under the Prospective Payment System (PPS), amounts imposed by the Federal False Claims Act, or the amounts determined by settlement between the hospitals and the OIG/DOJ Project Team (hereafter referred to as the Project Team); (2) require hospitals to refund amounts owed Medicare beneficiaries as a result of billing them for deductible and coinsurance amounts for the improper billings to Medicare; and (3) require hospitals to establish internal controls to prevent further improper billings for outpatient services.

Since the inception of the PPS in 1983, hospitals have billed Medicare for outpatient services that had been factored into the inpatient payment under PPS. The OIG has issued four reports to the Health Care Financing Administration identifying about $115.1 million in Medicare overpayments to hospitals caused by these improper billings. The fourth OIG report, issued in July 1994, identified 4,660 hospitals that submitted improper billings for outpatient services. An ongoing fifth OIG review has disclosed that the improper billings continue.

Clearly more needed to be done to convince hospitals that they were to be held accountable for ensuring that their Medicare bills are accurate. Representatives of the OIG discussed this issue with representatives of the DOJ's U.S Attorney's Office for the Middle District of Pennsylvania. The DOJ representatives believed that the claims identified in the OIG reports were false claims and subject to the Federal False Claims Act. Approval was sought and obtained from DOJ headquarters to pursue this issue jointly with the OIG.

A Project Team, consisting of staff of the OIG and DOJ, was established to analyze data relative to all 4,660 hospitals identified in the last OIG report issued, and notify them of their financial exposure under the Federal False Claims Act. The hospitals will be given the option of entering into a settlement agreement under which their financial exposure is substantially reduced. The agreement is based on a model settlement agreement reached with the Hospital Council of Western Pennsylvania, which represents 145 hospitals in Pennsylvania. Under the agreement the hospitals are ranked into three tiers, depending on the number of improper claims submitted and their bed size. The amount that the hospital must repay is based on the tier in which the hospital is placed.

To date, the Project Team has:

- Requested, from all 56 Medicare intermediaries, information needed on the individual hospitals included in the project. The cooperation of the intermediaries has been extremely good, and the Project Team has received virtually all of the information requested.

- Sent settlement agreement letters to the 145 hospitals requesting repayment of about $3.4 million for overpayments received as of December 31, 1991, and associated penalties. The hospitals must also agree to repay overpayments received after that date, and interest on all overpayments.

- Computed the financial exposure of 731 hospitals in Florida, Missouri, Mississippi, Louisiana, Indiana, Virginia, and West Virginia. Settlement agreement letters requesting a total of over $9.3 million in repayments will be mailed by September 30, 1995.

The Project Team estimates that upon completion of this project, repayments from hospitals, including penalties and interest, will approximate $100 million. Equally important, as a condition for settlement, hospitals will have to: (1) agree to repay beneficiaries for deductibles and coinsurance amounts improperly billed; and (2) establish controls to prevent improper billings for outpatient services.

The DOJ is aware of audit work on PPS hospitals incorrectly reporting hospital transfers as discharges, thus, under certain circumstances, being overpaid. The DOJ has requested that we provide hospital-specific updated information on these erroneous payments. It is our understanding that DOJ is considering plans to merge this data to the nonphysician services data and make a combined settlement for each hospital. We will contact you prior to arranging a meeting with DOJ so that we can agree on specific details for these recoveries.

If you have any questions, or wish additional information concerning the OIG/DOJ joint project, please call me or have your staff contact Mr. George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

STATUS REPORT - OFFICE OF INSPECTOR GENERAL/DEPARTMENT OF JUSTICE JOINT PROJECT--MEDICARE NONPHYSICIAN OUTPATIENT BILLS SUBMITTED BY HOSPITALS

JUNE GIBBS BROWN
Inspector General

AUGUST 1995
A-03-94-00021

Memorandum

Date AUG 29 1995

From June Gibbs Brown
Inspector General

Subject Status Report - Office of Inspector General/Department of Justice Joint Project--Medicare Nonphysician Outpatient Bills Submitted by Hospitals (A-03-94-00021)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This report is to inform you of the status of an ongoing nationwide project involving nonphysician outpatient bills submitted by hospitals paid under Medicare's prospective payment system (PPS). The project is being conducted jointly by the Office of Inspector General (OIG) and the Department of Justice (DOJ).

OBJECTIVES

The primary objectives of this joint OIG/DOJ project are to:

- Recover from hospitals, previously identified by the OIG as billing for outpatient services that were included in the inpatient payment under PPS, amounts imposed by the Federal False Claims Act, or the amounts determined by settlement between the hospitals and the OIG/DOJ Project Team (hereafter referred to as the Project Team).

- Require hospitals to refund amounts owed Medicare beneficiaries as a result of billing them for deductible and coinsurance amounts for the improper billings to Medicare.

- Require hospitals to establish internal controls to prevent further improper billings for outpatient services.

PRELIMINARY RESULTS

Since the inception of the PPS in 1983, hospitals have billed Medicare for outpatient services that had been factored into the inpatient payment under PPS. The OIG has issued four reports to the Health Care Financing Administration (HCFA) identifying about $115.1 million in Medicare overpayments to hospitals caused by these improper

billings. The fourth OIG report, issued in July 1994, identified 4,660 hospitals that submitted improper billings for outpatient services. An ongoing fifth OIG review has disclosed that the improper billings continue.

The OIG has identified 4,660 hospitals that submitted bills for outpatient services included in inpatient payments under PPS. The Project Team estimates that the project will result in recoveries of about $100 million from the hospitals, refunds to beneficiaries, and improved hospital controls.

Hospitals continued to bill improperly for nonphysician outpatient services despite our reports, and HCFA's positive responses to them. Clearly more needed to be done to convince hospitals that they were to be held accountable for ensuring that their Medicare bills are accurate. In this regard, the OIG joined with the DOJ in initiating a pilot project involving two hospitals located in Pennsylvania. Based on the outcome of this pilot, the OIG and DOJ agreed to establish a Project Team to expand the project nationwide to the 4,660 hospitals identified in the fourth OIG report.

The Project Team will analyze data relative to all 4,660 hospitals and notify them of their financial exposure under the Federal False Claims Act. The hospitals will be given the option of entering into a settlement agreement under which their financial exposure is substantially reduced. The Project Team anticipates that the vast majority of hospitals will opt for this alternative. To date, the Project Team has:

- Requested, from all 56 Medicare intermediaries, information needed on the individual hospitals included in the project.

- Reached a model settlement agreement with the Hospital Council of Western Pennsylvania which represents 145 hospitals included in this project. This model agreement will be used nationally.

- Sent settlement agreement letters to the 145 hospitals requesting repayment of about $3.4 million for overpayments received as of December 31, 1991, and associated penalties. The hospitals must also agree to repay overpayments received after that date, and interest on all overpayments.

- Computed the financial exposure of 731 hospitals in Florida, Missouri, Mississippi, Louisiana, Indiana, Virginia, and West Virginia. Settlement agreement letters requesting a total of over $9.3 million in repayments will be mailed by September 30, 1995.

The Project Team estimates that upon completion of this project, repayments from hospitals, including penalties and interest, will approximate $100 million. Equally

important, as a condition for settlement, hospitals will have to: (1) agree to repay beneficiaries for deductibles and coinsurance amounts improperly billed; and (2) establish controls to prevent improper billings for outpatient services.

BACKGROUND

Under PPS, Medicare intermediaries reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a diagnosis related group. Under current regulations, separate payments are not permitted for nonphysician outpatient services (such as radiology, other diagnostic tests, or laboratory services) provided within 72 hours of a Medicare beneficiary's inpatient admission to a hospital. Payments for these services are included in the inpatient payment under PPS.

Prior OIG Audit Reports

The OIG has issued four audit reports to HCFA pointing out that many hospitals, contrary to Federal regulations, have continually billed for outpatient services that are included in the inpatient payment under PPS. The Medicare intermediaries paid the bills on a fee-for-service basis, thus resulting in the hospitals receiving two payments for the same service. The four OIG reports identified Medicare overpayments totaling about $115.1 million arising from improper hospital billings. Preliminary results of a fifth review, now in progress, show that the improper billings continue.

The OIG identified the Medicare overpayments through a series of computer matches of general-care hospital inpatient claims data to nonphysician outpatient claims data, and a validation of results. Summary information on the prior OIG reports is shown below.

SUMMARY OF PRIOR OIG AUDIT REPORTS

OIG Reports	CIN	Date Issued	Period Covered	Validated Medicare Overpayments (Millions)
1	A-01-86-62024	7/14/88	10/1/83 to 1/31/86	$28.0
2	A-01-90-00516	8/13/90	2/1/86 to 11/30/87	40.0
3	A-01-91-00511	12/29/92	12/1/87 to 10/31/90	38.5
4	A-01-92-00521	7/6/94	11/1/90 to 12/31/91	8.6
Total				$115.1

In our reports to HCFA, we made a number of recommendations, most of which were agreed to by HCFA. In all of the reports, we recommended that the hospitals be required to refund the improper Medicare payments to their intermediary. We also

recommended that hospitals be required to refund the applicable coinsurance and deductible amounts to the affected beneficiaries. We estimated that the refunds to beneficiaries would be substantial--about $29 million for the last three reporting periods. The hospitals refunded about $101.3 million of the overpayments identified in the first three reviews. The Project Team subsequently requested HCFA to delay recovery action on the $8.6 million of overpayments identified in the fourth OIG review because of its potential effect on this nationwide joint project.

PILOT PROJECT AT TWO HOSPITALS IN PENNSYLVANIA

Although the overpayments to hospitals were getting lower--an average of about $1 million per month in the first OIG report to about $614,000 per month in the fourth OIG report--hospitals were still submitting improper bills for outpatient services 6 years after the problem was brought to their attention by the OIG and HCFA. Clearly, something more was needed to convince hospitals that business as usual was no longer acceptable, and that they are accountable for repeatedly submitting bills which result in Medicare overpayments. Representatives of the OIG discussed this issue with representatives of the DOJ's U.S Attorney's Office for the Middle District of Pennsylvania. The DOJ representatives believed that the claims identified in the OIG reports were false claims and subject to the Federal False Claims Act. Approval was sought and obtained from DOJ headquarters to pursue this issue jointly with the OIG.

Initially, we conducted a pilot review at two hospitals in Pennsylvania, hereafter referred to as Hospital A and Hospital B. Using the results of the prior OIG audit report (A-01-91-00511), we selected a statistical sample of claims to validate the overpayments identified in the prior report. We determined that 99 of the 100 selected claims at Hospital A and 97 of the selected claims at Hospital B were, in fact, overpayments caused by the hospitals billing for outpatient services included in the inpatient payment. Based on the results of our statistical sample, we recommended that Hospital A coordinate with the OIG Office of Investigations (OI) and Office of Civil Fraud and Administrative Adjudications (OCFAA) on the repayment of $275,412; and that Hospital B coordinate with OI and OCFAA on the repayment of $96,521.

We provided our results to DOJ who entered into a settlement agreement with Hospital A for about $576,000 (which consisted of the repayment of the overpayment and associated fines and penalties). A settlement agreement with Hospital B is nearing finalization. Based on the results of the pilot project, the OIG/DOJ established a Project Team to expand the project to the 4,660 hospitals identified in the fourth OIG audit report.

STATUS OF NATIONAL PROJECT

The Project Team will review all 4,660 hospitals identified in the fourth OIG report issued in July 1994, and send settlement letters to them. To date, all intermediaries have been contacted for information, a model settlement agreement has been developed, 145 hospital settlement letters have been mailed, and financial exposure has been computed for an additional 731 hospitals. The Project Team estimates that total recoveries from the hospitals will total about $100 million when the project is complete.

Contacts With Intermediaries

The Project Team has contacted the 56 Medicare intermediaries that serviced the 4,660 hospitals, and requested the amounts recovered as a result of the prior OIG reviews and copies of correspondence with the hospitals. The intermediaries were reminded that they were not to collect the overpayments identified in the fourth OIG report for the period November 1, 1990 through December 31, 1991.

The cooperation of the intermediaries has been extremely good, and the Project Team has received virtually all of the information requested.

Model Settlement Agreement Reached and Letters Mailed

The Project Team initially focused its efforts on 145 hospitals serviced by VERITUS, one of three Medicare intermediaries servicing hospitals located in Pennsylvania (the other two intermediaries are Independent Blue Cross and AEtna of Fort Washington). By letter dated December 1, 1994, the Project Team notified the hospitals of their potential financial exposure to a civil prosecution pursuant to the Federal False Claims Act. The financial exposure was based on the: (1) recoupment of unrecovered overpayments; (2) assessment of treble damages; and (3) a mandatory minimum penalty of $5,000 per false claim. The Project Team offered the hospitals the opportunity to settle the matter before litigation.

Upon receipt of the letter, the hospitals, through the Hospital Council of Western Pennsylvania, attempted to reach settlement with the Project Team. The Council established the "Pittsburgh Working Group" to reach a settlement which recognized the concerns and interests of the affected parties. The model settlement agreement agreed to by the "Pittsburgh Working Group" and the Project Team includes: (1) overpayments identified in the third and fourth OIG reports and beyond; (2) the ranking of the hospitals into tiers based primarily on a ratio of the number of false claims submitted to their bed size; and (3) the computation of the repayment based on the tier in which the hospital is placed. Each tier consisted of 1/3 the number of hospitals, with hospitals with 10 or less false claims being grouped in tier 1. Tier 1 includes those hospitals with the lowest false claims to bed size ratio while tier 3 includes those hospitals with the highest ratio (and thus the most flagrant violators).

As shown in the following table, the model settlement agreement requires hospitals to pay a penalty based on the tier in which they are placed. Penalties imposed on overpayments identified in the third OIG report (A-01-91-00511) are based on the identification of actual overpayments after validation at each hospital, and are in addition to the repayments already made by the hospitals. Penalties imposed on overpayments identified in the fourth OIG report (A-01-92-00521) are based on the potential overpayments that were identified through the series of computer matches prior to any validation at the individual hospitals. The Project Team does not intend to perform validations at the 4,660 hospitals because: (1) of the resources required to conduct the validations; and (2) the terms of the model settlement agreement are already far more generous than the provisions of the Federal False Claims Act.

HOSPITALS' FINANCIAL EXPOSURE BASED ON SETTLEMENT AGREEMENT

OIG Reports	Tier 1	Tier 2	Tier 3
3	None	Penalty--75 percent of actual overpayments recovered by intermediary.	Penalty--100 percent of actual overpayments recovered by intermediary.
4	Potential overpayments plus interest.	Payment and penalty--100 percent of potential overpayments, plus interest.	Payment and penalty--300 percent of potential overpayments, plus interest.

The above chart takes in all overpayments received by hospitals as of December 31, 1991. As part of the model settlement agreement, hospitals are also required to repay all overpayments received after that date up to the date of settlement. Interest will be paid on all overpayments.

Aside from the repayment required by the model settlement agreement, there are two other important provisions. One requires the hospital to conduct a review of patient accounts and records to identify instances where the Medicare beneficiaries (or the Medicaid program if the person was dually eligible for both Medicare and Medicaid) paid the hospital for deductibles or coinsurance. Within 90 days of settlement, the hospital shall refund, when feasible, the amount identified. A second provision of the settlement requires the hospital to establish both computerized and manual controls to prevent future billing for outpatient services included in the inpatient payment under PPS.

The Project Team will use this model settlement agreement with all 4,660 hospitals included in the project. It is anticipated that most of the hospitals will chose this option in lieu of litigation under the Federal False Claims Act which allows for a minimum penalty of $5,000 for each false claim.

Following the methodology stipulated in the model settlement agreement for determining the repayment amount, the Project Team sent settlement agreement letters to the 145 hospitals requesting repayment of about $3.4 million. Further, under the terms of the settlement agreement, the hospitals are required to repay all overpayments received after December 31, 1991 to the date of settlement, and the interest on all overpayments. The Project Team is preparing settlement agreement letters for the remaining 70 hospitals in Pennsylvania which are serviced by the other 2 Pennsylvania intermediaries. The Project Team estimates that recoveries from all 215 Pennsylvania hospitals will total about $6 million.

Financial Exposure of 731 Hospitals

The Project Team has completed its analysis of 731 hospitals serviced by Blue Cross and Blue Shield of Florida, Blue Cross and Blue Shield of Louisiana, AdminaStar, and Trigon, Inc. As shown below, the hospitals' financial exposure under the Federal False Claims Act is substantially higher than their exposure under the model settlement agreement.

FINANCIAL EXPOSURE OF 731 HOSPITALS

Intermediary	State	Hospitals	Financial Exposure	
			Federal False Claims Act	Planned Settlement Agreement
Blue Cross/Blue Shield of Florida	Florida	185	$ 39,058,590	$3,850,983
Blue Cross/Blue Shield of Mississippi	Missouri	125	206,862,470	665,065
" "	Mississippi	83	27,044,247	274,227
" "	Louisiana	86	77,650,442	1,084,993
AdminaStar	Indiana	113	192,162,736	2,251,102
Trigon, Inc.	Virginia	91	83,257,539	904,055
" "	West Virginia	48	35,654,482	342,740
		731	$661,690,506	$9,373,164

By September 30, 1995, the Project Team will have sent settlement agreement letters to the 731 hospitals requesting repayment of $9,373,164. This amount includes overpayments as of December 31, 1991. All additional overpayments up to the date of settlement as well as interest owed on all overpayments must also be repaid by each of the 731 hospitals if the particular hospital is to avoid litigation under the Federal False Claims Act.

Future Work on Project

The Project Team will focus its efforts State by State until all 4,660 hospitals identified as having submitted improper bills for outpatient services are analyzed, financial exposures developed, and settlement agreement letters sent to each hospital. The Project Team expects that work will continue under this project for the next several months.

We appreciate the Medicare intermediary's cooperation in this joint project, just as we appreciate HCFA's cooperation with regard to, not only this project, but also our previous reviews of outpatient hospital services. The media has expressed interest in this joint OIG/DOJ project, and it is possible that this interest will intensify as the project is expanded to additional States. For this reason, we believe it important that HCFA be kept aware of the progress of the project.

OTHER MATTERS

The DOJ is aware of audit work on PPS hospitals incorrectly reporting hospital transfers as discharges, thus, under certain circumstances, being overpaid. The DOJ has requested that we provide hospital-specific updated information on these erroneous payments. We are currently preparing this updated information. It is our understanding that DOJ is considering plans to merge this data to the nonphysician services data and make a combined settlement for each hospital. We will contact you prior to arranging a meeting with DOJ so that we can agree on specific details for these recoveries.

If you have any questions, or wish additional information concerning the OIG/DOJ joint project, please call me or have your staff contact Mr. George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 966-7104.