Memorandum

Date MAY 16 2001

From Michael F. Mangano
Acting Inspector General

Subject Review of Potentially Excessive Medicare Payments for Outpatient Services
(A-01-00-00502)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's final report entitled, "Review of Potentially Excessive Medicare Payments for Outpatient Services." The objective of our review was to evaluate controls used to detect potentially excessive Medicare payments made to institutional providers for outpatient services. Our review covered high dollar claims paid during Calendar Years 1997, 1998, and 1999.

We found that simple clerical provider billing errors on 13 outpatient claims generated $12 million in excessive Medicare payments to institutional providers. Although the providers eventually returned these overpayments, the Health Care Financing Administration (HCFA) and fiscal intermediaries (FI) did not have sufficient edits in their standard Medicare claims processing systems to preclude the overpayments from being made. Consequently, reliance is placed on providers or beneficiaries to disclose any overpayments to their FIs. Otherwise, the Medicare trust fund will be reduced by any overpayments. Even if reported, overpayments result in lost interest to the Medicare trust fund. For instance, due to the $12 million of excessive Medicare payments mentioned above, as much as $106,000 of interest was lost because these overpayments remained outstanding for various amounts of time ranging from 10 to 431 days.

We, therefore, recommend that HCFA implement a Common Working File edit to reject potentially excessive Medicare payments for pre-payment review (this edit should reject outpatient claims with expected payment amounts that meet or exceed an appropriate dollar threshold); identify and collect any additional overpayments made on other outpatient claims that have the potential for excessive payments; and stress the importance of standard Medicare claims processing system edits to FIs. In response to our draft report, HCFA concurred with our recommendations and plans to take corrective action to detect and prevent potentially excessive Medicare payments for outpatient services.

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 contact 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-01-00-00502 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF POTENTIALLY EXCESSIVE MEDICARE PAYMENTS FOR OUTPATIENT SERVICES

MAY 2001
A-01-00-00502

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From Michael F. Mangano
Acting Inspector General

Subject Review of Potentially Excessive Medicare Payments for Outpatient Services
(A-01-00-00502)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides you with the results of our review of potentially excessive Medicare payments for outpatient services.

EXECUTIVE SUMMARY

OBJECTIVE

The objective of our review was to evaluate controls used to detect potentially excessive Medicare payments made to institutional providers for outpatient services. Our review covered high dollar claims paid during Calendar Years (CY) 1997, 1998, and 1999.

FINDINGS

Simple clerical provider billing errors on 13 outpatient claims generated $12 million in excessive Medicare payments to institutional providers. For example, 1 provider incorrectly billed Medicare for 91,798 units of service when only 1 unit of service was actually rendered. Further analysis disclosed that the claim's date of service (recorded as 9-17-98) was improperly entered as the units of service. This billing error generated an overpayment in excess of $4 million.

Although the providers eventually returned these overpayments, the Health Care Financing Administration (HCFA) and fiscal intermediaries (FI) did not have sufficient edits in their standard Medicare claims processing systems to preclude the overpayments from being made. Consequently, reliance is placed on: 1) providers to notify their FIs of any overpayments, or 2) beneficiaries to review their Explanation of Medicare Benefits letters or Medicare Summary Notices and disclose any overpayments to their FIs. Otherwise, the Medicare trust fund will be reduced by any overpayments. Even if reported, overpayments result in lost interest to the Medicare trust fund. For instance, due to the $12 million of excessive Medicare payments mentioned above, as much as $106,000 of interest was lost

because these overpayments remained outstanding for various amounts of time ranging from 10 to 431 days.

We believe that improvements can be made to preclude such overpayments from occurring in the future. Furthermore, this issue is especially critical since the new Outpatient Prospective Payment System (OPPS) can generate significantly higher overpayments for billing errors that are similar to those that we identified.

In response to our draft report, HCFA concurred with our recommendations and plans to take corrective action to detect and prevent potentially excessive Medicare payments for outpatient services. The full text of HCFA's response is included as ATTACHMENT V.

RECOMMENDATIONS

We recommend that HCFA:

❶ Implement a Common Working File (CWF) edit to reject potentially excessive Medicare payments for pre-payment review. This edit should reject outpatient claims with expected payment amounts that meet or exceed an appropriate dollar threshold. Depending on this threshold, we believe this edit would only reject a minimal number of claims nationwide.

❷ Identify and collect any additional overpayments made on other outpatient claims that have the potential for excessive payments.

❸ Stress the importance of standard Medicare claims processing system edits to FIs.

The Office of Inspector General (OIG) will continue to monitor excessive payments through our annual audit of HCFA's financial statements and through provider specific audits focused on particular types of service.

INTRODUCTION

BACKGROUND

Two incidents led to the initiation of this review. First, OIG received correspondence from a beneficiary who questioned an excessive Medicare payment. In this case, the provider submitted charges for medical supplies of $1.1 million when the actual charges were only $436. Second, during a prior HCFA financial statement audit, OIG found that an FI overpaid a provider approximately $1.2 million for one outpatient claim. This occurred because the provider billed Medicare for 320,000 units of service when only 10 units of

service were actually rendered. In this case, the FI's standard claim processing system did not have sufficient edits in place to evaluate the reasonableness of the provider submitted units of service.

LAWS AND REGULATIONS

Title XVIII of the Social Security Amendments of 1965, the Medicare legislation, established a health insurance program for aged persons. Under sections 1816(a) and 1842(a) of the Social Security Act, public or private organizations and agencies may participate in the administration of the Medicare program. The FIs contract with HCFA to administer Medicare Part A and institutional Part B claims. The FIs' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Intermediary Manual section 3700 states:

> *"It is essential that you* [the FI] *maintain adequate internal controls over Title XVIII automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."*

The FIs currently use two standard systems to process outpatient claims - the Fiscal Intermediary Standard System (FISS) and the Arkansas Part A Standard System. In addition, the CWF can detect improper payments when processing claims for pre-payment validation.

Claims for outpatient services originate at the provider. Hospital Manual section 462 states:

> *"In order to be paid correctly and promptly, a bill must be completed accurately."*

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

The Balanced Budget Act of 1997 mandated that HCFA implement a Medicare prospective payment system for hospital outpatient services. To this end, HCFA implemented OPPS. Payment for services under OPPS is calculated based on grouping services into ambulatory payment classification (APC) groups. Services within an APC are clinically similar and require similar resources. The payment rate and coinsurance amount calculated for an APC apply to all of the services within the APC group. The OPPS became effective for covered services provided on or after August 1, 2000.

The Balanced Budget Refinement Act of 1999 established major provisions that affected the development and implementation of OPPS. Some of these provisions allow providers to

receive reimbursements that are in addition to APC payments. Two of these additional amounts are:

- outlier adjustments that are based on submitted charges, adjusted to costs, for all OPPS services included on the submitted outpatient bill (outlier payments were established to cover some of the additional cost of providing care that exceeds established thresholds); and

- interim transitional corridor payments to limit a provider's losses under OPPS.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. The objective was to evaluate controls used to detect potentially excessive Medicare payments made to institutional providers for outpatient services.

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- utilized HCFA's National Claims History (NCH) file to develop frequency distributions of claim paid amounts for outpatient claims paid during CYs 1997, 1998, and 1999 (see ATTACHMENTS I, II, and III, respectively);

- identified 120 outpatient claims (with a total Medicare claim paid amount of $19,889,444) from the NCH file that had Medicare claim paid amounts equaling or exceeding $50,000 and that were paid during CYs 1997, 1998, and 1999;

- reviewed available CWF on-line claim histories for these 120 claims to determine if the claims had been canceled and superseded with revised claims (there were no available on-line claim histories for all CY 1997 and some CY 1998 claims);

- identified 13 claims (with a total Medicare claim paid amount of $12,044,544) that were canceled and superseded with revised claims during CYs 1998 and 1999;

- contacted personnel from some of the FIs that processed these 13 claims; and

- determined if OPPS could generate overpayments to providers who submit claims with OPPS services that have excessive units or charges.

We did not determine whether an overpayment occurred on the remaining 107 claims because their CWF on-line claim histories were not available or did not show that the claims were canceled. As such, medical review would have been required to determine the causes of any overpayments that may have been associated with the 107 claims. Medical review was not available to us. The total Medicare claim paid amount for these 107 claims is $7,844,900.

Our review allowed us to establish a reasonable assurance regarding the authenticity and accuracy of the data obtained from the NCH file. Our audit was not directed towards assessing the completeness of this file. Our field work was conducted from February 2000 through September 2000 at Associated Hospital Services - Massachusetts, Associated Hospital Services - Maine, Blue Cross of Maryland, and the OIG regional office in Boston, Massachusetts.

FINDINGS AND RECOMMENDATIONS

Provider billing errors on 13 outpatient claims generated $12 million in excessive Medicare payments to institutional providers. The following billing errors caused these overpayments:

- 3 claims had overstated service units because the providers incorrectly entered the claims' dates of service in the "SERVICE UNITS" field - $11,075,686 in overpayments;
- 5 claims had overstated "TOTAL CHARGES"- $642,175 in overpayments; and
- 5 claims had overstated service units for various reasons - $316,230 in overpayments.

Although the providers eventually returned these overpayments, HCFA and FIs did not have sufficient edits in their standard Medicare claims processing systems to preclude the overpayments from being made. Consequently, reliance is placed on: 1) providers to notify their FIs of any overpayments, or 2) beneficiaries to review their Explanation of Medicare Benefits letters or Medicare Summary Notices and disclose any overpayments to their FIs. Otherwise, the Medicare trust fund will be reduced by any overpayments. Even if reported, overpayments result in lost interest to the Medicare trust fund. For instance, due to the $12 million of excessive Medicare payments mentioned above, as much as $106,000 of interest was lost because these overpayments remained outstanding for various amounts of time ranging from 10 to 431 days.

Additionally, our analysis demonstrates that OPPS is vulnerable to billing errors that are similar to those we identified. In fact, the OPPS payment methodology could generate

significantly higher overpayments than those made under the former cost reimbursement system.

CAUSES AND EXAMPLES OF THE EXCESSIVE PAYMENTS

The underlying cause for the 13 overpayments was that HCFA and FIs did not have sufficient edits in their standard Medicare claims processing systems to preclude the overpayments from being made. Below are examples of these overpayments and their related causes.

Example 1 - Three Claims for Clinic Services with Overstated Units - Providers Incorrectly Entered Dates of Service in the "SERVICE UNITS" Field :

Date of Service	Number of Units Provided	Charged Amount	Paid Amount
09/17/98	91798	$55.00	$4,186,034.40
07/30/98	73098	$65.00	$3,362,508.00
08/07/98	80798	$41.00	$3,527,279.09
Total		$161.00	$11,075,821.49

In each instance, the providers submitted claims with overstated units by entering the dates of service in the "SERVICE UNITS" field on the Medicare claim forms. Prior to these overpayments, the FI reinstalled a revised FISS reasonableness edit that would have identified these excessive units. However, FI officials advised us they inadvertently turned off this edit. The three overpayments occurred during the 1-week period that the edit was turned off. After being notified by the providers, the FI recovered the overpayments and determined that no similar overpayments were made.

Example 2 - One Claim for a Rural Health Clinic Service with Overstated Charges:

	Date of Service	Charged Amount	Paid Amount
Original Claim	12/08/98	$510,051.00	$408,040.80
Revised Claim	12/08/98	$51.00	$40.80

The FI generated this overpayment because the provider submitted the original claim with overstated charges. This claim was subsequently canceled and the provider submitted a revised claim with charges of $51.00. The provider entered the charge of $51.00 twice in

the "TOTAL CHARGES" field on the original Medicare claim form. While the FI's standard system had a reasonableness edit to suspend claims with total charges of $1 million or more, this edit was not sufficient to preclude this overpayment since the total charges were only $510,051.00. The FI lowered the threshold of this reasonableness edit to $250,000 in January 2000.

Example 3 - One Claim for an End Stage Renal Disease (ESRD) Service with Overstated Units:

	Number of Units of EPOGEN® Claimed	EPOGEN® Reimbursement
Original Claim	7,500,000	$75,000.00
Revised Claim	75,000	$750.00
Overpayment		$74,250.00

The FI made this overpayment because the provider overstated the number of EPOGEN® units claimed. The provider did not submit a revised claim until 5 months later. There is no HCFA requirement to edit for and suspend EPOGEN® claims with excessive units if the patient dialyzes in an ESRD facility (as is the case with the above claim). There is a HCFA requirement to edit for and suspend EPOGEN® claims with excessive units for patients that dialyze at home.

Two of the FIs in our examples took corrective measures by reinstalling a reasonableness edit for units (Example 1) and lowering the dollar threshold on a reasonableness edit for charges (Example 2). However, we believe FI reasonableness edits are not sufficient to prevent the types of overpayments we found since:

- FIs can turn off edits;
- FI-created edits are not standardized and may not exist at all FIs; and
- FIs can set reasonableness edit thresholds too high.

LOST INTEREST TO THE MEDICARE TRUST FUND

Medicare trust funds are invested in United States Treasury Special Issues when the funds are not necessary to meet current expenditures. The $12 million in overpayments was not available for investing for varying amounts of time that ranged from 10 to 431 days. As such, we estimated that as much as $106,000 of interest was lost (see ATTACHMENT IV).

EFFECT ON THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM

The OPPS is vulnerable to the same billing errors that we described above. Furthermore, the payment structure of OPPS has the potential for generating significantly greater overpayments than the former cost reimbursement system. Specifically, OPPS can generate overpayments to providers who submit claims with OPPS services that have excessive units or charges.

Excessive Units:

The OPPS' Outpatient Code Editor (OCE) edits claim data to identify errors and to assign APC numbers to services (claim line items) that are covered by OPPS. The OCE then inputs claim data into a PRICER program that calculates provider reimbursements by multiplying the standard APC rates by the provider submitted units of service.

As such, overstated units of service will generate excessive APC payments to providers. While the OCE is designed to flag claims with line item units of service that exceed a set threshold, there are certain services or circumstances where no threshold has been established; i.e., drugs. Furthermore, FIs can ignore these flags and pay the providers based on all the submitted units.

Excessive Charges:

Under OPPS, overstated charges submitted by providers can result in the generation of additional payments in the form of outlier payments and/or monthly transitional corridor payments. The following example illustrates the overpayment that would have occurred under OPPS for 1 of the 13 overpayments that we identified as being made under the former cost reimbursement system. This example shows that the OPPS system would have generated a significantly higher overpayment than the former reimbursement methodology.

	Cost Reimbursement System	OPPS
Submitted Charges	$3,011,272.00	$3,011,272.00
Correct Charges	$1,900.00	$1,900.00
Original Paid Amount	$60,225.44	NA
APC Payment	NA	$356.33
Outlier Adjustment	NA	$435,199.44
Correct Paid Amount	$38.00	$356.33
Overpayment	$60,187.44	$435,199.44

RECOMMENDATIONS

We recommend that HCFA:

❶ Implement a CWF edit to reject potentially excessive Medicare payments for pre-payment review. This edit should reject outpatient claims with expected payment amounts that meet or exceed an appropriate dollar threshold. Depending on this threshold, we believe this edit would only reject a minimal number of claims nationwide.

❷ Identify and collect any additional overpayments made on other outpatient claims that have the potential for excessive payments.

❸ Stress the importance of standard Medicare claims processing system edits to FIs.

The OIG will provide HCFA with the necessary supporting detail for all 120 outpatient claims that we identified as having claim paid amounts equaling or exceeding $50,000 and that were paid during CYs 1997, 1998, and 1999.

HCFA's RESPONSE

The HCFA concurred with our recommendations and plans to: 1) implement a CWF edit to reject potentially excessive Medicare payments for pre-payment review, 2) instruct FIs to identify any additional claims where inappropriate payments were made due to overstated units of service or overstated total charges, and 3) stress the importance of standard Medicare claims processing system edits to FIs and work with FIs to identify system edit problems.

1997 FREQUENCY DISTRIBUTION OF OUTPATIENT CLAIMS

Dollar Range							
Lower Limit	Upper Limit	Number of Claims	Paid Amount	Average Claim Paid Amount	Cumulative Number of Claims	Cumulative Paid Amount	Cumulative Paid Amount As a Percentage of Total
$100,000.00		10	$1,371,681.16	$137,168.12	10	$1,371,681.16	0.01%
$95,000.00	$99,999.99	3	$292,143.98	$97,381.33	13	$1,663,825.14	0.01%
$90,000.00	$94,999.99	1	$94,281.47	$94,281.47	14	$1,758,106.61	0.01%
$85,000.00	$89,999.99	0	$0.00	$0.00	14	$1,758,106.61	0.01%
$80,000.00	$84,999.99	5	$419,309.13	$83,861.83	19	$2,177,415.74	0.01%
$75,000.00	$79,999.99	0	$0.00	$0.00	19	$2,177,415.74	0.01%
$70,000.00	$74,999.99	3	$218,928.86	$72,976.29	22	$2,396,344.60	0.01%
$65,000.00	$69,999.99	1	$69,326.40	$69,326.40	23	$2,465,671.00	0.01%
$60,000.00	$64,999.99	7	$443,491.42	$63,355.92	30	$2,909,162.42	0.02%
$55,000.00	$59,999.99	7	$404,561.77	$57,794.54	37	$3,313,724.19	0.02%
$50,000.00	$54,999.99	8	$418,428.72	$52,303.59	45	$3,732,152.91	0.02%
$49,000.00	$49,999.99	1	$49,398.22	$49,398.22	46	$3,781,551.13	0.02%
$48,000.00	$48,999.99	4	$193,478.68	$48,369.67	50	$3,975,029.81	0.02%
$47,000.00	$47,999.99	2	$94,771.29	$47,385.65	52	$4,069,801.10	0.02%
$46,000.00	$46,999.99	6	$278,515.70	$46,419.28	58	$4,348,316.80	0.03%
$45,000.00	$45,999.99	3	$135,708.14	$45,236.05	61	$4,484,024.94	0.03%
$44,000.00	$44,999.99	5	$222,036.48	$44,407.30	66	$4,706,061.42	0.03%
$43,000.00	$43,999.99	5	$217,610.22	$43,522.04	71	$4,923,671.64	0.03%
$42,000.00	$42,999.99	9	$382,709.55	$42,523.28	80	$5,306,381.19	0.03%
$41,000.00	$41,999.99	6	$248,413.68	$41,402.28	86	$5,554,794.87	0.03%
$40,000.00	$40,999.99	1	$40,375.14	$40,375.14	87	$5,595,170.01	0.03%
$39,000.00	$39,999.99	6	$238,190.30	$39,698.38	93	$5,833,360.31	0.03%
$38,000.00	$38,999.99	4	$153,464.04	$38,366.01	97	$5,986,824.35	0.03%
$37,000.00	$37,999.99	4	$149,351.48	$37,337.87	101	$6,136,175.83	0.04%
$36,000.00	$36,999.99	8	$292,932.96	$36,616.62	109	$6,429,108.79	0.04%
$35,000.00	$35,999.99	7	$249,565.96	$35,652.28	116	$6,678,674.75	0.04%
$34,000.00	$34,999.99	8	$276,969.03	$34,496.13	124	$6,954,643.78	0.04%
$33,000.00	$33,999.99	8	$268,719.51	$33,589.94	132	$7,223,363.29	0.04%
$32,000.00	$32,999.99	5	$162,293.05	$32,458.61	137	$7,385,656.34	0.04%
$31,000.00	$31,999.99	16	$504,212.67	$31,513.29	153	$7,889,869.01	0.05%

Dollar Range					Cumulative		Cumulative Paid
Lower Limit	Upper Limit	Number of Claims	Paid Amount	Average Claim Paid Amount	Number of Claims	Cumulative Paid Amount	Amount As a Percentage of Total
$30,000.00	$30,999.99	16	$490,649.99	$30,665.62	169	$8,380,519.00	0.05%
$29,000.00	$29,999.99	11	$324,833.59	$29,530.33	180	$8,705,352.59	0.05%
$28,000.00	$28,999.99	27	$767,633.53	$28,430.87	207	$9,472,986.12	0.05%
$27,000.00	$27,999.99	28	$768,420.79	$27,443.60	235	$10,241,406.91	0.06%
$26,000.00	$26,999.99	30	$792,795.92	$26,426.53	265	$11,034,202.83	0.06%
$25,000.00	$25,999.99	25	$636,539.20	$25,461.57	290	$11,670,742.03	0.07%
$24,000.00	$24,999.99	31	$759,687.55	$24,506.05	321	$12,430,429.58	0.07%
$23,000.00	$23,999.99	44	$1,032,180.18	$23,458.64	365	$13,462,609.76	0.08%
$22,000.00	$22,999.99	40	$898,608.47	$22,465.21	405	$14,361,218.23	0.08%
$21,000.00	$21,999.99	59	$1,268,770.70	$21,504.59	464	$15,629,988.93	0.09%
$20,000.00	$20,999.99	89	$1,824,749.26	$20,502.80	553	$17,454,738.19	0.10%
$19,000.00	$19,999.99	91	$1,776,272.98	$19,519.48	644	$19,231,011.17	0.11%
$18,000.00	$18,999.99	126	$2,329,774.24	$18,490.27	770	$21,560,785.41	0.13%
$17,000.00	$17,999.99	152	$2,655,216.28	$17,468.53	922	$24,216,001.69	0.14%
$16,000.00	$16,999.99	203	$3,346,920.05	$16,487.29	1,125	$27,562,921.74	0.16%
$15,000.00	$15,999.99	283	$4,387,793.82	$15,504.57	1,408	$31,950,715.56	0.19%
$14,000.00	$14,999.99	496	$7,163,476.77	$14,442.49	1,904	$39,114,192.33	0.23%
$13,000.00	$13,999.99	654	$8,797,179.00	$13,451.34	2,558	$47,911,371.33	0.28%
$12,000.00	$12,999.99	1,007	$12,554,550.14	$12,467.08	3,565	$60,465,921.47	0.35%
$11,000.00	$11,999.99	1,345	$15,412,313.70	$11,458.97	4,910	$75,878,235.17	0.44%
$10,000.00	$10,999.99	1,948	$20,411,396.22	$10,478.13	6,858	$96,289,631.39	0.56%
$9,000.00	$9,999.99	3,127	$29,557,367.19	$9,452.31	9,985	$125,846,998.58	.073%
$8,000.00	$8,999.99	5,058	$42,775,665.46	$8,457.03	15,043	$198,180,031.23	1.15%
$7,000.00	$7,999.99	8,337	$62,195,535.46	$7,460.18	23,380	$260,375,566.69	1.51%
$6,000.00	$6,999.99	13,825	$89,211,140.97	$6,452.89	37,205	$349,586,707.66	2.02%
$5,000.00	$5,999.99	25,275	$137,617,629.37	$5,444.81	62,480	$487,204,337.03	8.82%
$4,000.00	$4,999.99	53,319	$236,179,701.63	$4,429.56	115,799	$723,384,038.66	4.19%
$3,000.00	$3,999.99	144,914	$492,659,649.53	$3,399.67	260,713	$1,216,043,688.19	7.04%
$2,200.00	$2,999.99	819,107	$1,921,652,020.13	$2,346.03	1,079,820	$3,137,695,708.32	18.17%
$1,000.00	$1,999.99	3,019,133	$4,364,283,173.12	$1,445.54	4,098,953	$7,501,978,881.44	43.45%
$999.99		99,056,362	$9,763,398,912.40	$98.56	103,155,315	$17,265,377,793.84	100.00%

1998 FREQUENCY DISTRIBUTION OF OUTPATIENT CLAIMS

Dollar Range Lower Limit	Upper Limit	Number of Claims	Paid Amount	Average Claim Paid Amount	Cumulative Number of Claims	Cumulative Paid Amount	Cumulative Paid Amount As a Percentage of Total
$100,000.00		5	$11,587,604.05	$2,317,520.81	5	$11,587,604.05	0.07%
$95,000.00	$99,999.99	1	$99,571.19	$99,571.19	6	$11,687,175.24	0.07%
$90,000.00	$94,999.99	0	$0.00	$0.00	6	$11,687,175.24	0.07%
$85,000.00	$89,999.99	1	$87,614.62	$87,614.62	7	$11,774,789.86	0.07%
$80,000.00	$84,999.99	1	$82,538.28	$82,538.28	8	$11,857,328.14	0.07%
$75,000.00	$79,999.99	0	$0.00	$0.00	8	$11,857,328.14	0.07%
$70,000.00	$74,999.99	3	$216,229.80	$72,076.60	11	$12,073,557.94	0.07%
$65,000.00	$69,999.99	1	$69,286.91	$69,286.91	12	$12,142,844.85	0.07%
$60,000.00	$64,999.99	2	$124,924.61	$62,462.31	14	$12,267,769.46	0.07%
$55,000.00	$59,999.99	3	$174,891.65	$58,297.22	17	$12,442,661.11	0.08%
$50,000.00	$54,999.99	7	$363,939.05	$51,991.29	24	$12,806,600.16	0.08%
$49,000.00	$49,999.99	2	$98,927.51	$49,463.76	26	$12,905,527.67	0.08%
$48,000.00	$48,999.99	3	$145,477.42	$48,492.47	29	$13,051,005.09	0.08%
$47,000.00	$47,999.99	1	$47,408.12	$47,408.12	30	$13,098,413.21	0.08%
$46,000.00	$46,999.99	2	$92,426.78	$46,213.39	32	$13,190,839.99	0.08%
$45,000.00	$45,999.99	3	$136,962.26	$45,654.09	35	$13,327,802.25	0.08%
$44,000.00	$44,999.99	2	$88,632.40	$44,316.20	37	$13,416,434.65	0.08%
$43,000.00	$43,999.99	3	$129,629.70	$43,209.90	40	$13,546,064.35	0.08%
$42,000.00	$42,999.99	2	$85,698.79	$42,849.40	42	$13,631,763.14	0.08%
$41,000.00	$41,999.99	6	$247,766.55	$41,294.43	48	$13,879,529.69	0.08%
$40,000.00	$40,999.99	8	$324,137.72	$40,517.22	56	$14,203,667.41	0.09%
$39,000.00	$39,999.99	5	$197,618.11	$39,523.62	61	$14,401,285.52	0.09%
$38,000.00	$38,999.99	6	$231,168.16	$38,528.03	67	$14,632,453.68	0.09%
$37,000.00	$37,999.99	4	$149,728.70	$37,432.18	71	$14,782,182.38	0.09%
$36,000.00	$36,999.99	4	$146,582.30	$36,645.58	75	$14,928,764.68	0.09%
$35,000.00	$35,999.99	9	$319,281.62	$35,475.74	84	$15,248,046.30	0.09%
$34,000.00	$34,999.99	6	$207,011.58	$34,501.93	90	$15,455,057.88	0.09%
$33,000.00	$33,999.99	10	$334,451.53	$33,445.15	100	$15,789,509.41	0.10%
$32,000.00	$32,999.99	9	$291,291.25	$32,365.69	109	$16,080,800.66	0.10%
$31,000.00	$31,999.99	12	$376,214.62	$31,351.22	121	$16,457,015.28	0.10%

Dollar Range							
Lower Limit	Upper Limit	Number of Claims	Paid Amount	Average Claim Paid Amount	Cumulative Number of Claims	Cumulative Paid Amount	Cumulative Paid Amount As a Percentage of Total
$30,000.00	$30,999.99	14	$427,142.38	$30,510.17	135	$16,884,157.66	0.10%
$29,000.00	$29,999.99	29	$851,908.43	$29,376.15	164	$17,736,066.09	0.11%
$28,000.00	$28,999.99	27	$767,199.22	$28,414.79	191	$18,503,265.31	0.11%
$27,000.00	$27,999.99	19	$521,120.47	$27,427.39	210	$19,024,385.78	0.12%
$26,000.00	$26,999.99	41	$1,084,864.83	$26,460.12	251	$20,109,250.61	0.12%
$25,000.00	$25,999.99	34	$865,405.92	$25,453.12	285	$20,974,656.53	0.13%
$24,000.00	$24,999.99	43	$810,382.54	$24,557.05	328	$21,785,039.07	0.13%
$23,000.00	$23,999.99	50	$1,175,583.94	$23,511.68	368	$22,960,623.01	0.14%
$22,000.00	$22,999.99	59	$1,326,006.86	$22,474.69	427	$24,286,629.87	0.15%
$21,000.00	$21,999.99	59	$1,264,880.10	$21,438.65	486	$25,551,509.97	0.15%
$20,000.00	$20,999.99	96	$1,968,485.66	$20,505.06	582	$27,519,995.63	0.17%
$19,000.00	$19,999.99	106	$2,060,909.72	$19,442.54	688	$29,580,905.35	0.18%
$18,000.00	$18,999.99	177	$3,276,743.82	$18,512.68	865	$32,857,649.17	0.20%
$17,000.00	$17,999.99	223	$3,905,129.74	$17,511.79	1,088	$36,762,778.91	0.22%
$16,000.00	$16,999.99	257	$4,229,010.98	$16,455.30	1,345	$40,991,789.89	0.25%
$15,000.00	$15,999.99	359	$5,555,031.76	$15,473.63	1,704	$46,546,821.65	0.28%
$14,000.00	$14,999.99	575	$8,308,532.66	$14,449.62	2,279	$54,855,354.31	0.33%
$13,000.00	$13,999.99	811	$10,928,485.34	$13,475.32	3,090	$65,783,839.65	0.40%
$12,000.00	$12,999.99	1,174	$14,636,239.00	$12,466.98	4,264	$80,420,078.65	0.49%
$11,000.00	$11,999.99	1,622	$18,584,779.24	$11,457.94	5,886	$99,004,857.89	0.60%
$10,000.00	$10,999.99	2,201	$23,037,747.91	$10,466.96	8,087	$122,042,605.80	0.74%
$9,000.00	$9,999.99	3,438	32,498,609.92	$9,452.77	11,525	$154,541,215.72	0.94%
$8,000.00	$8,999.99	5,090	$43,082,492.38	$8,464.14	16,615	$197,623,708.10	1.20%
$7,000.00	$7,999.99	8,004	59,703,546.64	$7,459.21	24,619	$257,327,254.74	1.56%
$6,000.00	$6,999.99	12,970	$83,693,763.56	$6,452.38	37,590	$341,021,018.30	2.06%
$5,000.00	$5,999.99	23,204	126,337,374.00	$5,444.64	60,794	$467,358,392.30	2.83%
$4,000.00	$4,999.99	50,454	223,298,893.02	$4,425.79	111,248	$690,657,285.32	4.18%
$3,000.00	$3,999.99	148,259	502,989,970.67	$3,392.64	259,507	$1,193,647,255.99	7.22%
$2,000.00	$2,999.99	824,179	1,940,651,151.89	$2,354.65	1,083,686	$3,134,298,407.88	18.97%
$1,000.00	$1,999.99	2,752,367	4,003,419,291.71	$1,454.54	3,836,053	$7,137,717,699.59	43.20%
$0.00	$999.99	99,538,479	9,386,646,191.45	$94.30	103,374,532	$16,524,363,891.04	100.00%

1999 FREQUENCY DISTRIBUTION OF OUTPATIENT CLAIMS

Dollar Range		Number of Claims	Paid Amount	Average Claim Paid Amount	Cumulative Number of Claims	Cumulative Paid Amount	Cumulative Paid Amount As a Percentage of Total
Lower Limit	Upper Limit						
$100,000.00		1	$141,705.59	$141,705.59	1	$141,705.59	0.00%
$95,000.00	$99,999.99	0	$0.00	$0.00	1	$141,705.59	0.00%
$90,000.00	$94,999.99	1	$90,508.19	$0.00	2	$232,213.78	0.00%
$85,000.00	$89,999.99	1	$86,493.20	$86,493.20	3	$318,706.98	0.00%
$80,000.00	$84,999.99	6	$495,766.99	$82,627.83	9	$814,473.97	0.01%
$75,000.00	$79,999.99	3	$237,382.40	$0.00	12	$1,051,856.37	0.01%
$70,000.00	$74,999.99	3	$218,113.83	$72,704.61	15	$1,269,970.20	0.01%
$65,000.00	$69,999.99	3	$201,036.36	$67,012.12	18	$1,471,006.56	0.01%
$60,000.00	$64,999.99	10	$622,297.75	$62,229.78	28	$2,093,304.31	0.01%
$55,000.00	$59,999.99	14	$783,738.41	$55,981.32	42	$2,877,042.72	0.02%
$50,000.00	$54,999.99	9	$473,647.79	$52,627.58	51	$3,350,690.51	0.02%
$49,000.00	$49,999.99	4	$198,938.03	$49,734.51	55	$3,549,628.54	0.02%
$48,000.00	$48,999.99	2	$96,950.33	$48,475.17	57	$3,646,578.87	0.02%
$47,000.00	$47,999.99	4	$191,098.70	$47,774.68	61	$3,837,677.57	0.02%
$46,000.00	$46,999.99	2	$93,050.52	$46,525.26	63	$3,930,728.09	0.02%
$45,000.00	$45,999.99	4	$181,178.63	$45,294.66	67	$4,111,906.72	0.03%
$44,000.00	$44,999.99	3	$134,432.29	$44,810.76	70	$4,246,339.01	0.03%
$43,000.00	$43,999.99	4	$172,811.16	$43,202.79	74	$4,419,150.17	0.03%
$42,000.00	$42,999.99	3	$126,722.88	$42,240.96	77	$4,545,873.05	0.03%
$41,000.00	$41,999.99	10	$413,760.12	$41,376.01	87	$4,959,633.17	0.03%
$40,000.00	$40,999.99	0	$0.00	$0.00	87	$4,959,633.17	0.03%
$39,000.00	$39,999.99	5	$197,676.08	$39,535.22	92	$5,157,309.25	0.03%
$38,000.00	$38,999.99	2	$77,405.89	$38,702.95	94	$5,234,715.14	0.03%
$37,000.00	$37,999.99	7	$262,571.45	$37,510.21	101	$5,497,286.59	0.03%
$36,000.00	$36,999.99	7	$256,349.07	$36,621.30	108	$5,753,635.66	0.04%
$35,000.00	$35,999.99	2	$70,818.75	$35,409.38	110	$5,824,454.41	0.04%
$34,000.00	$34,999.99	1	$34,928.86	$34,928.86	111	$5,859,383.27	0.04%
$33,000.00	$33,999.99	10	$335,444.11	$33,544.41	121	$6,194,827.38	0.04%
$32,000.00	$32,999.99	13	$420,034.28	$32,310.33	134	$6,614,861.66	0.04%
$31,000.00	$31,999.99	19	$599,642.01	$31,560.11	153	$7,214,503.67	0.05%

Dollar Range					Cumulative		Cumulative Paid
Lower Limit	Upper Limit	Number of Claims	Paid Amount	Average Claim Paid Amount	Number of Claims	Cumulative Paid Amount	Amount As a Percentage of Total
$30,000.00	$30,999.99	35	$1,071,447.02	$30,612.77	268	$8,285,950.69	0.05%
$29,000.00	$29,999.99	31	$913,923.30	$29,481.40	219	$9,199,873.99	0.06%
$28,000.00	$28,999.99	37	$1,057,627.03	$28,584.51	256	$10,257,501.02	0.06%
$27,000.00	$27,999.99	43	$1,183,921.26	$27,533.05	299	$11,441,422.28	0.07%
$26,000.00	$26,999.99	47	$1,244,500.50	$26,478.73	346	$12,685,922.78	0.08%
$25,000.00	$25,999.99	62	$1,580,255.09	$25,487.99	408	$14,266,177.87	0.09%
$24,000.00	$24,999.99	79	$1,941,016.06	$24,569.82	487	$16,207,193.93	0.10%
$23,000.00	$23,999.99	85	$2,003,186.11	$23,566.90	572	$18,210,380.04	0.11%
$22,000.00	$22,999.99	78	$1,753,183.02	$22,476.71	650	$19,963,563.06	0.13%
$21,000.00	$21,999.99	105	$2,254,522.51	$21,471.64	755	$22,218,085.57	0.14%
$20,000.00	$20,999.99	136	$2,787,816.74	$20,498.65	891	$25,005,902.31	0.16%
$19,000.00	$19,999.99	140	$2,721,256.81	$19,437.55	1,031	$27,727,159.12	0.17%
$18,000.00	$18,999.99	170	$3,132,671.56	$18,427.48	1,201	$30,859,830.68	0.19%
$17,000.00	$17,999.99	219	$3,827,335.32	$17,476.42	1,420	$34,687,166.00	0.22%
$16,000.00	$16,999.99	278	$4,591,501.79	$16,516.19	1,698	$39,278,667.79	0.25%
$15,000.00	$15,999.99	398	$6,163,362.93	$15,485.84	2,096	$45,442,030.72	0.28%
$14,000.00	$14,999.99	568	$8,215,771.02	$14,460.86	2,664	$53,655,801.74	0.34%
$13,000.00	$13,999.99	756	$10,182,273.05	$13,468.62	3,420	$63,838,074.79	0.40%
$12,000.00	$12,999.99	1,046	$12,926,793.28	$12,489.66	4,466	$76,764,868.07	0.48%
$11,000.00	$11,999.99	1,379	$15,821,668.43	$11,473.29	5,834	$92,586,536.50	0.58%
$10,000.00	$10,999.99	2,140	$22,374,454.17	$10,455.35	7,974	$114,960,990.67	0.72%
$9,000.00	$9,999.99	2,959	$28,007,524.36	$9,465.20	10,933	$142,968,515.03	0.90%
$8,000.00	$8,999.99	4,391	$37,165,626.77	$8,464.05	15,324	$180,134,141.80	1.13%
$7,000.00	$7,999.99	6,248	$46,679,652.92	$7,471.14	21,572	$226,813,794.72	1.42%
$6,000.00	$6,999.99	10,224	$65,997,075.77	$6,455.11	31,796	$292,810,870.49	1.83%
$5,000.00	$5,999.99	18,546	$100,919,400.66	$5,441.57	50,342	$393,730,271.15	2.47%
$4,000.00	$4,999.99	42,659	$188,407,555.19	$4,416.60	93,001	$582,137,826.34	3.65%
$3,000.00	$3,999.99	148,284	$501,366,438.26	$3,381.12	241,285	$1,083,504,264.60	6.79%
$2,000.00	$2,999.99	835,420	$1,973,586,761.92	$2,362.37	1,076,712	$3,057,091,026.52	19.16%
$1,000.00	$1,999.99	2,440,778	$3,581,572,567.93	$1,467.39	3,517,490	$6,638,663,594.45	41.60%
$0.00	$999.99	101,802,144	$9,319,691,977.11	$91.55	105,319,634	$15,958,355,571.56	100.00%

ATTACHMENT IV

CALCULATION OF LOST INTEREST

Original Medicare Payment Amount	Revised Medicare Payment Amount	Difference	Original Payment Date	Canceled Date	Days Outstanding	Interest Lost @ 8.75%	Interest Lost @ 5.875%
$70,601.40	$3,129.30	$67,472.10	12/21/1998	08/25/1999	247	$4,050.67	$2,719.73
$50,007.50	$12.50	$49,995.00	04/05/1999	04/15/1999	10	$121.52	$81.59
$56,234.58	$218.70	$56,015.88	02/16/1999	04/01/1999	44	$599.06	$402.23
$408,040.80	$40.80	$408,000.00	03/12/1999	04/01/1999	20	$1,983.33	$1,331.67
$3,362,508.00	$46.00	$3,362,462.00	03/15/1999	05/03/1999	49	$40,045.99	$26,888.02
$4,186,034.40	$45.60	$4,185,988.80	03/08/1999	04/01/1999	24	$24,418.27	$16,395.12
$3,527,279.09	$44.00	$3,527,235.09	03/05/1999	04/02/1999	28	$24,004.79	$16,117.50
$61,556.03	$2,156.03	$59,400.00	11/10/1998	04/26/1999	167	$2,411.06	$1,618.86
$86,493.20	$2,276.30	$84,216.90	08/14/1999	09/01/1999	18	$368.45	$247.39
$64,990.45	$1,054.45	$63,936.00	03/29/1999	06/02/2000	431	$6,697.74	$4,497.05
$60,225.44	$38.00	$60,187.44	09/14/1999	10/20/1999	36	$526.64	$353.60
$50,681.52	$181.62	$50,499.90	08/30/1999	09/16/1999	17	$208.66	$140.10
$59,891.39	$1,209.06	$58,682.33	10/11/1999	11/16/1999	36	$513.47	$344.76
[redacted]	[redacted]	[redacted]				[redacted]	[redacted]

Section 1841 of the Social Security Act require Medicare Part B Trust Fund investments be invested in interest bearing obligations of the United States. United States Treasury Special Issues are special public obligations for exclusive purchase by the Medicare trust fund. Interest rates range from 5.875 percent to 8.750 percent.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: APR 11 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: *Review of Potentially Excessive Medicare Payments for Outpatient Services* (A-01-00-00502)

Thank you for the opportunity to review OIG's draft report concerning its evaluation of the controls used to detect potentially excessive Medicare payments made to institutional providers for outpatient services.

The Balanced Budget Act of 1997 required the Health Care Financing Administration (HCFA) to replace the cost-based system with the outpatient prospective payment system (PPS), which pays hospitals specific predetermined payment rates for outpatient services. The law also changed the way beneficiary coinsurance is determined for services under the outpatient PPS.

The Balanced Budget Refinement Act of 1999 also contained a number of major provisions affecting the outpatient PPS that have been incorporated in the regulation to help ensure a smoother transition to the new system for hospitals and establish special payments for new drugs and technologies.

The outpatient prospective payment system (OPPS) includes most hospital outpatient services and Medicare Part B services furnished to hospital inpatients who have no Part A coverage. Excluded from the OPPS by law are ambulance services for which a new fee schedule is being developed. HCFA will continue to pay physician services separately under Medicare's physician fee schedule. HCFA will also continue to use existing fee schedules to pay for physical, occupational, and speech therapies; durable medical equipment; clinical diagnostic laboratory services; and non-implantable orthotics and prosthetics.

The OIG found that simple clerical billing errors by the provider on 13 outpatient claims generated $12 million in excessive Medicare payments to institutional providers. The OIG believes that improvements can be made to preclude such overpayments from occuring in the future. This issue is especially critical since the new OPPS can generate significantly higher overpayments for billing errors that are similar to those identified by OIG.

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As a result, OIG has suggested that HCFA implement the following recommendations:

OIG Recommendation
HCFA should implement a Common Working File (CWF) edit to reject potentially excessive Medicare payments for pre-payment review. This edit should reject outpatient claims with expected payment amounts that meet or exceed an appropriate dollar threshold. Depending on this threshold, OIG believes this edit would only reject a minimal number of claims nationwide.

HCFA Response
We concur. We will develop a CWF edit to reject potentially excessive Medicare payments for pre-payment review as recommended.

OIG Recommendation
HCFA should identify and collect any additional overpayments made on other outpatient claims that have the potential for excessive payments.

HCFA Response
We concur. We will instruct the fiscal intermediaries (FIs) to use their mass adjustment process to identify any claims where inappropriate payments have been made due to overstated units of service or overstated total charges.

OIG Recommendation
HCFA should stress the importance of standard Medicare claims processing system edits to FIs.

HCFA Response
We concur. Since the implementation of the OPPS, HCFA has used a series of new edits through the Outpatient Code Editor (OCE) to ensure proper payment under this system for outpatient services provided by hospitals and community mental health centers. These edits include, but are not limited to, correct coding edits and unit of service edits. The unit of service edits are currently being further refined by HCFA and will be updated in a future version of the OCE. Claims for outpatient services rendered by providers, which are not subject to the OPPS, also go through this code editor. Therefore, they are subject to standard editing for all FI operations. We will continue to stress the importance of standard Medicare claims processing system edits to our FIs and will work with them to identify potential system edit problems.