DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date JUN - 5

From Michael F. Mangano
Acting Inspector General

Subject 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)

To

Thomas Scully
Administrator
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's (OIG) final report entitled, "Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System." We identified a potential $47.6 million in improper payments made by Medicare for Calendar Year 1999 for services covered by the consolidated billing provision of the skilled nursing facility (SNF) prospective payment system (PPS).

This review determined that the Medicare program is paying twice for the same service--once to the SNF under the Medicare Part A PPS and again to an outside supplier under Medicare Part B. These improper payments occurred because Medicare edits have not been established to detect and prevent supplier claims noncompliant with the consolidated billing provision. Our recommendations to the Health Care Financing Administration (HCFA) include: establish payment edits within the common working file; continue to work with OIG to identify and recover improper payments made subsequent to the implementation of the consolidated billing provision; direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the consolidated billing provision; and monitor the contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis. In response to our draft report, HCFA concurred with our recommendations.

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 at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-00-00538 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF POTENTIAL IMPROPER PAYMENTS MADE BY MEDICARE PART B FOR SERVICES COVERED UNDER THE PART A SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM

JUNE 2001
A-01-00-00538

EXECUTIVE SUMMARY

BACKGROUND

Under the consolidated billing provision of the prospective payment system (PPS) for skilled nursing facilities (SNF), the SNF is responsible for billing Medicare for virtually all of the services rendered to its residents in a Medicare Part A stay. As a result, outside suppliers of services to SNF residents must now bill the SNF rather than the Medicare program. This review was performed as a follow-up action to our report (A-01-99-00531) dated March 2000 which found the Medicare program was paying twice for the same service--once to the SNF under the Part A PPS and again to an outside supplier under Medicare Part B.

OBJECTIVE

The objective of our review was to determine the extent of improper payments made by Medicare Part B to outside suppliers for services already included in the Medicare Part A prospective payment to the SNF. The period covered by our review is Calendar Year (CY) 1999. To accomplish our objective, we performed a nationwide computer match, using the Health Care Financing Administration's (HCFA) National Claims History file, to identify improper payments made by Part B to suppliers.

SUMMARY OF FINDINGS

Based on our nationwide computer match, we identified a potential $47.6 million in improper payments made by Medicare Part B to suppliers for services that were already included in the PPS payment that Part A made to the SNF for a covered stay. We also found instances where suppliers billed and were paid by both the SNF and Part B. We found the following types of services most vulnerable:

Type of Service	Potential Nationwide Improper Payments (in millions)
Outpatient Hospital Department	$15.8
Ambulance	$12.8
Laboratory	$9.4
Radiology	$5.9
Durable Medical Equipment	$3.7
Total	$47.6

CAUSE AND RECOMMENDATIONS

The results of our review show that some suppliers are still not fully cognizant of the consolidated billing provision and, as a result, continue to improperly bill Medicare contractors. Medicare improper payments continue to occur because HCFA has not yet established edits within the common working file (CWF) and contractors' claims processing systems to detect improperly billed claims and prevent payments.

We recommend HCFA establish payment edits within the CWF and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision. The Office of Inspector General (OIG) will assist HCFA with this initiative as necessary. Pending the implementation of payment edits, we recommend HCFA adopt these interim remedies:

- Continue to work with OIG to identify and recover improper payments made subsequent to the implementation of the consolidated billing provision.

- Direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the SNF PPS consolidated billing provision.

- Monitor the Medicare contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis. The OIG will provide HCFA with detailed claims information to assist in the recovery process.

In response to our draft report, HCFA concurred with each of the recommendations. The HCFA indicated that it will be finalizing implementation of an automated process in the near future. In the interim, HCFA is developing a strategy to 1) identify mistaken payments and 2) establish methodologies that allow Medicare contractors to effectively recover overpayments. Furthermore, HCFA recently completed a training conference for contractors to discuss the consolidated billing policy and to provide information on upcoming systems changes designed to prevent duplicate billing. In addition, HCFA instructed contractors to provide training to ensure their providers/suppliers understand program requirements and billing procedures. Lastly, HCFA will direct the applicable Medicare contractors to recover the potential $47.6 million in overpayments.

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INTRODUCTION

BACKGROUND

The Balanced Budget Act (BBA) of 1997 requires implementation of a Medicare SNF PPS for cost reporting periods beginning on or after July 1, 1998. Under the PPS, SNFs are no longer paid in accordance with the reasonable cost-based system but rather through per diem prospective case-mix adjusted payment rates applicable to all covered SNF services. These payment rates cover virtually all costs of furnishing skilled nursing services (that is, routine, ancillary, and capital-related costs).

The BBA also set forth a consolidated billing requirement applicable to all SNFs providing Medicare services. Under consolidated billing, the SNF is responsible for billing Medicare for most of the services rendered to its residents in a Medicare Part A stay.[1] The SNFs are no longer able to unbundle services to an outside supplier that can submit a separate bill directly to the Medicare Part B carrier. Instead, the SNF must furnish the services either directly or under arrangements with outside suppliers. The outside supplier must then bill the SNF for the services rendered.

Section 1888(e)(2)(A)(ii) of the Social Security Act excludes certain services from the consolidated billing requirement. These include several types of practitioner services that are exempt and thus, are still to be billed separately to the Part B carrier. Emergency and intensive services provided to a SNF resident in an outpatient hospital department (OPD) are also excluded from consolidated billing and are billed by the hospital to the fiscal intermediary (FI). Other services not subject to the consolidated billing provision include dialysis services and supplies, hospice care related to a beneficiary's terminal condition, and ambulance transportation to the SNF for the initial admission or from the SNF following a final discharge, or to and from OPDs for the purpose of receiving excluded emergency or intensive type services. The Balanced Budget Refinement Act of 1999 expanded the list of excluded services to include ambulance services furnished in conjunction with dialysis services, certain chemotherapy and radioisotope services, and certain prosthetics.

On March 27, 2000, we issued a final report to HCFA entitled, "Review of Compliance with the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities (A-01-99-00531)." In this pilot review that led to our current report on this issue, we found that for over one-third of SNF PPS claims that we reviewed, Medicare paid twice for the

[1]Medicare Part A helps pay for up to 100 days of skilled care in a SNF during a benefit period. After that time, the beneficiary is no longer eligible for the Medicare Part A benefits but remains eligible for Medicare Part B benefits. The Part A benefit period begins the first day a beneficiary receives a Medicare-covered service as an inpatient in a Medicare certified hospital and ends when the beneficiary has been out of a hospital or other facility that mainly provided skilled nursing or rehabilitation services for 60 days in a row.

same service--once to the SNF under the Part A PPS and again to an outside supplier under Part B. Improper payments occurred because the Part B suppliers billed Medicare directly and Medicare edits have not been established to detect and prevent these types of improper claims. Also, some suppliers are not fully cognizant of the consolidated billing provision and, as a result, improperly billed FIs and carriers. Pending the implementation of program edits, HCFA concurred with our recommendation to jointly develop a computer application with OIG to identify and recover overpayments made to suppliers during CY 1999.

OBJECTIVES, SCOPE, AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objective of our review was to determine the extent of improper payments made by Medicare Part B to outside suppliers for services already included in the Medicare Part A prospective payment to the SNF. The period covered by our review is CY 1999. We limited consideration of the internal control structure to the payment controls in place within the CWF and selected Medicare contractors Part A and Part B claims processing systems to ensure compliance with the consolidated billing requirement. The objective of our review did not require an understanding or assessment of the complete internal control structure at HCFA or its contractors.

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- performed a nationwide computer match, using HCFA's National Claims History file, of all SNF PPS stays with discharges in CY 1999 to Part B services rendered by suppliers to SNF residents to identify payments made by Part B to suppliers for services subject to consolidated billing (see APPENDIX D for our computer match methodology);[2]

- reviewed a judgmental sample of 65 claims for SNF PPS stays submitted by 3 free-standing SNFs and 3 hospital-based SNFs, and 71 associated Part B services rendered by suppliers during the selected SNF stays to validate the results of our computer match for CY 1999;

- reviewed the CWF Part B, outpatient, and Durable Medical Equipment Regional Carrier (DMERC) summary records and detail claim history to confirm that

[2]Our nationwide computer match included payments to 14,136 SNFs. Of this number, 701 were not under the PPS as of January 1, 1999. These non-PPS SNFs all became PPS during CY 1999 as their cost reporting date passed. Since we could not identify a cost reporting period for non-PPS SNFs prior to January 1, 1999, we could not eliminate the payments that occurred prior to their conversion to PPS.

Medicare made separate payments to suppliers for services that were already reimbursed to the SNF through the PPS;

- met with representatives of the selected SNFs to discuss the sampled claims, to obtain additional documentary evidence of noncompliance with consolidated billing, and to identify issues to facilitate revisions to our computer match; and

- discussed the results of our review with HCFA central office.

In completing our review of the sample, we established a reasonable assurance on the authenticity and accuracy of the data. Our audit was not directed toward assessing the completeness of the file from which the data was obtained.

The three FIs that processed the judgmental sample of SNF claims selected for our review included United HealthCare Insurance Company, Associated Hospital Service of Maine, and Blue Cross and Blue Shield of Alabama. The claims for the Part B services rendered during the selected SNF stays were processed by National Heritage Insurance Company, United HealthCare Insurance Company, Anthem Insurance Companies, Empire Medicare Services, and Associated Hospital Service of Maine.

We conducted our review from April 2000 to October 2000 at the Region I, Office of Audit Services in Boston, Massachusetts and at selected SNFs in Connecticut and Massachusetts.

The HCFA's written comments to our draft report are appended in their entirety to this report (see APPENDIX E) and are summarized on page 8.

FINDINGS AND RECOMMENDATIONS

As part of the SNF PPS, the consolidated billing provision represents a relatively new payment policy designed to curb excessive Medicare expenditures. Accordingly, we acknowledge HCFA's efforts toward the development of implementing regulations and guidelines. However, the results of our review show that some suppliers are still not fully cognizant of the consolidated billing provision and continue to improperly bill Medicare contractors. Based on our nationwide computer match, we identified a potential $47.6 million in improper payments made by Medicare Part B to suppliers for services that were already included in the PPS payment that Part A made to the SNF for a covered stay. As a result, the Medicare program is paying twice for the same service--once to the SNF under the Part A prospective payment and again to an outside supplier under Part B. We also found instances where suppliers billed and were paid by both the SNF and Part B. Medicare improper payments continue to occur because HCFA has not yet established edits within the CWF and contractors' claims processing systems to detect improperly billed claims and prevent payments.

We designed several computer applications, utilizing HCFA's claims payment data, to identify potential improper payments made by Part B to suppliers during CY 1999 for services covered under the consolidated billing provision. *It is important to note that the potential $47.6 million in improper payments developed through the computer match is an amount which represents actual provider-specific overpayments, not an amount based on a statistical projection of sample results.* As a means of validating the results of the computer match, we judgmentally selected three free-standing and three hospital-based SNFs located in Connecticut and Massachusetts, respectively. For these SNFs, we reviewed a judgmentally selected sample of 65 claims for beneficiary SNF stays and 71 associated nonphysician Part B supplier services rendered during those stays in order to:

- substantiate our results and continue to revise the parameters of the computer applications as necessary to obtain a population of potentially improper claims;
- identify additional control weaknesses contributing to supplier noncompliance with the consolidated billing provision; and
- determine whether some suppliers are billing both the SNF and Medicare.

Based on detailed claims analysis and subsequent discussions with the SNFs, suppliers, and HCFA, we determined that 27 of the 71 Part B supplier services were not subject to the consolidated billing provision. Accordingly, we revised the parameters of our computer applications to reflect the results of our validation work in order to provide HCFA and OIG with the best measure of potential improper payments.

We did not extend our audit work beyond the sample because, in our professional judgment, the results obtained from additional audit work would not have produced different results. We base this conclusion on the results of our judgmental sample and the results of our pilot review (A-01-99-00531).

POTENTIAL IMPROPER PAYMENTS BY SERVICE

Medicare Part B made improper payments for services rendered by outside suppliers to beneficiaries in a covered Medicare Part A SNF stay. The suppliers incorrectly billed Part B for the services instead of the SNFs. The services were already reimbursed to the SNFs through the Part A PPS. Based on the results of our nationwide computer match and subsequent field work to validate the match, we found the following types of services most vulnerable to improper payments: OPD, ambulance, laboratory, radiology, and durable medical equipment (DME) (see Figure 1).

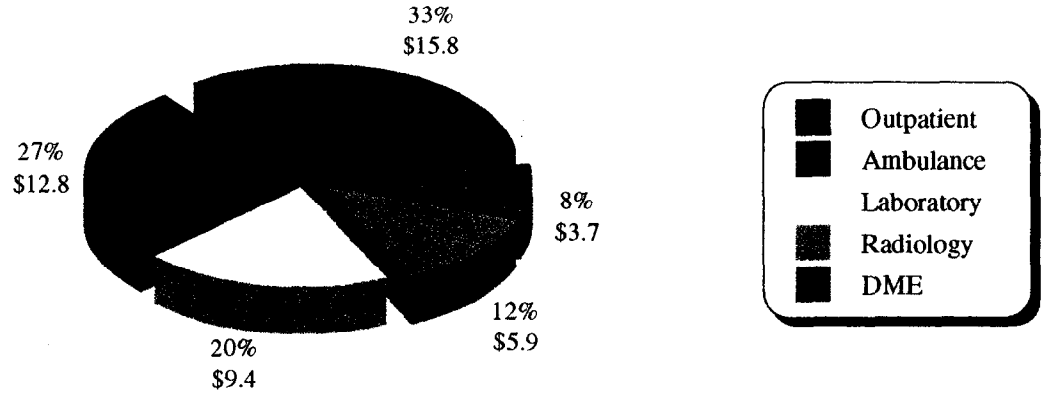

Figure 1 - Potential Nationwide Part B Improper Payments for CY 1999 (in millions)

OUTPATIENT HOSPITAL DEPARTMENT

When a SNF resident receives outpatient services at a hospital, the SNF retains the overall financial responsibility for essentially the entire package of care furnished during the outpatient visit other than the small number of exceptionally intensive services (i.e., MRI, CT scans, and cardiac catheterization) that lie well beyond the scope of care that SNFs would normally furnish, as well as emergency and end stage renal disease (ESRD) services. Through our computer application, we identified $15.8 million in potentially improper payments made by Medicare to OPDs for services that should have been billed to SNFs. If the OPDs billed correctly, the SNFs should have paid the OPDs for these services through the SNFs' Part A prospective payment. The most prevalent types of potential errors found in the OPD setting were diagnostic clinical laboratory and diagnostic radiology services. We also found instances of OPDs billing the FI for minor ambulatory surgical center procedures.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on August 27, 1999 and discharged on September 30, 1999. On September 11, 1999, an OPD performed clinical laboratory services for the beneficiary and billed the Medicare FI. Our validation work indicated this was a routine diagnostic procedure for which the OPD should have billed the SNF rather than Medicare.

AMBULANCE

The consolidated billing provision requires that ambulance suppliers bill the SNF for any services furnished to a SNF resident during a covered Part A stay, except for trips that occur at the beginning or end of the SNF stay, or for transportation to an OPD for the purpose of receiving excluded emergency or intensive type services.

Our match identified $12.8 million in potentially improper payments made to suppliers by Part B for non-emergency ambulance transportation costs that should have been paid by SNFs.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on February 25, 1999 and discharged on March 22, 1999. On March 4, 1999, the beneficiary was transported by ambulance to a free-standing MRI center. The ambulance supplier billed Part B instead of the SNF and was paid $455. The MRIs and the associated ambulance transportation are only excluded from consolidated billing when performed at an OPD.

LABORATORY

Laboratory services furnished to a SNF resident during a covered Part A stay must be billed to the SNF unless the services meet the requirements for payment under the physician fee schedule. Our match identified $9.4 million in potentially improper payments inappropriately billed by laboratory service suppliers to Part B instead of the SNF. We also found instances where suppliers billed both Part B and the SNF. We have referred one supplier to our Office of Investigations for further review.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on April 21, 1999 and discharged on April 30, 1999. On April 26, 1999, a laboratory test was performed by an independent laboratory. The laboratory billed both the SNF and Part B.

RADIOLOGY

Under consolidated billing, only the professional component of a diagnostic test (representing the interpretation that the physician performs personally) is billed separately as a physician service, while the technical component representing the diagnostic test itself, must be billed to the SNF. We identified $5.9 million in potentially improper payments inappropriately billed by radiology

service suppliers to Part B instead of the SNF. The potentially improper payment amount represents the technical component of the radiology service. We found:

- Some free-standing MRI centers are billing Part B for the technical component of MRIs instead of billing the SNF. The technical component of MRI procedures performed at free-standing MRI centers is not excluded from consolidated billing. Conversely, MRI procedures are considered intensive services and excluded from the consolidated billing provision only when performed in an OPD.

- Some physicians are billing Part B for both the technical component and the professional component of the radiology procedure. This billing practice is known as global billing and is not allowed under the SNF PPS consolidated billing provision. Physicians should bill the SNF for the technical component of the procedure and Part B for the professional component.

- Some portable radiology suppliers are billing Part B instead of the SNF for the technical component of portable radiology services rendered to a beneficiary while in the SNF.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on December 26, 1998 and discharged on January 21, 1999. On January 4, 1999, an MRI was performed at a free-standing MRI center. The technical component of the MRI was incorrectly billed to Part B instead of the SNF. As a result, Medicare overpaid the supplier $396.

DURABLE MEDICAL EQUIPMENT

The DME suppliers must bill the SNF when items are furnished to a SNF resident during a covered Part A stay. Our match identified $3.7 million in potentially improper payments inappropriately billed by DME suppliers to the DMERC instead of the SNF for supplies delivered to the SNF.

EXAMPLE OF NONCOMPLIANCE
A beneficiary was admitted to a SNF on November 23, 1998 and discharged on March 3, 1999. During the SNF stay, a DME supplier delivered enteral nutrition to the SNF location several times for this beneficiary. The supplier should have billed the SNF. Instead, the supplier billed the DMERC and was overpaid $1,644.

CONCLUSION AND RECOMMENDATIONS

The results of our review show that some suppliers are still not fully cognizant of the consolidated billing provision and, as a result, continue to improperly bill Medicare contractors. Medicare improper payments continue to occur because HCFA has not yet established edits within the CWF and contractors' claims processing systems to detect improperly billed claims and prevent payments.

We recommend HCFA establish payment edits within the CWF and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision. The OIG will assist HCFA with this initiative as necessary. Pending the implementation of payment edits, we recommend HCFA adopt these interim remedies:

- Continue to work with OIG to identify and recover potential improper payments made in subsequent years.

- Direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the SNF PPS consolidated billing provision.

- Monitor the Medicare contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis. The OIG will provide HCFA with detailed claims information to assist in the recovery process.

HCFA COMMENTS

In response to our draft report, HCFA concurred with each of the recommendations. The HCFA indicated that it will be finalizing implementation of an automated process in the near future. However, the complexity of the systems changes needed to automate the consolidated billing policy makes implementation of an automated system difficult at this time without creating an unacceptable level of risk. In the interim, HCFA is developing a strategy to 1) identify mistaken payments and 2) establish methodologies that allow Medicare contractors to effectively and efficiently recover overpayments. Furthermore, HCFA recently completed a training conference

for contractors to discuss the consolidated billing policy and to provide information on upcoming systems changes designed to prevent duplicate billing. In addition, HCFA instructed contractors to provide training to ensure their providers/suppliers understand program requirements and billing procedures. Lastly, HCFA will direct the applicable Medicare contractors to recover the potential $47.6 million in overpayments. The HCFA also provided technical comments which we have addressed below.

ADDITIONAL OIG COMMENTS

The HCFA concurred with the OIG methodology for matching SNF PPS and Part B claims, however, it suggested two minor clarifications in the methodology section. Regarding HCFA's first technical comment, as discussed in Footnote 2 on page 2 of the report, we acknowledge that 701 of the 14,136 SNFs were not under the PPS as of January 1, 1999. Subsequently, all 701 of the SNFs became PPS during the initial months of CY 1999. Although we were unable to eliminate from our match the payments that occurred prior to their conversion to PPS, we believe the amounts are not material. With regard to HCFA's second technical comment, we excluded from our match all laboratory and radiology services which may have been associated with the excluded outpatient intensive or emergency service, including those services provided by an independent laboratory or radiology center.

APPENDICES

SUMMARY BY FISCAL INTERMEDIARY
Potential Improper Payments

	Fiscal Intermediary	Amount
00010	Blue Cross and Blue Shield of Alabama	$105,804
00020	Arkansas Blue Cross and Blue Shield	$151,912
00030	Blue Cross and Blue Shield of Arizona, Inc.	$88,528
00040	Blue Cross of California	$670,613
00060	Anthem Insurance Companies - Connecticut	$174,381
00090	Blue Cross and Blue Shield of Florida, Inc.	$1,129,562
00101	Blue Cross and Blue Shield of Georgia, Inc.	$164,704
00130	Anthem Insurance Companies - Indiana	$441,646
00131	Anthem Insurance Companies - Illinois	$626,459
00140	Wellmark, Inc. - Iowa	$158,393
00150	Blue Cross and Blue Shield of Kansas, Inc.	$146,918
00160	Anthem Insurance Companies - Kentucky	$163,655
00180	Associated Hospital Service of Maine - Maine	$195,699
00181	Associated Hospital Service of Maine - Massachusetts	$636,980
00190	Blue Cross and Blue Shield of Maryland, Inc.	$703,658
00220	Noridian Mutual Insurance Company - Minnesota	$152,257
00230	Blue Cross and Blue Shield of Mississippi	$296,453
00250	Blue Cross and Blue Shield of Montana, Inc.	$103,542
00260	Blue Cross and Blue Shield of Nebraska	$50,970
00270	Blue Cross and Blue Shield of New Hampshire	$102,262
00280	Horizon Blue Cross and Blue Shield of New Jersey, Inc.	$303,797
00308	Empire Medicare Services	$860,791
00310	Blue Cross and Blue Shield of North Carolina	$225,173
00320	Noridian Mutual Insurance Company - North Dakota	$131,348
00332	Anthem Insurance Companies - Ohio	$696,517
00340	Blue Cross and Blue Shield of Oklahoma	$128,492
00350	Blue Cross Blue Shield of Oregon	$234,676
00363	Veritus Medicare Services - Pennsylvania	$815,357
00370	Blue Cross and Blue Shield of Rhode Island	$69,360
00380	Palmetto Government Benefits Administrators	$131,673
00390	Riverbend Government Benefits Administrators	$1,035,913
00400	Trailblazers Health Enterprises, LLC	$988,197

	Fiscal Intermediary	Amount
00410	Regence Blue Cross and Blue Shield of Utah	$88,649
00423	United Government Services - Virginia	$309,438
00430	Premera Blue Cross	$334,145
00450	United Government Services - Wisconsin	$548,599
00452	United Government Services - Michigan	$453,658
00453	United Government Services - West Virginia	$117,572
00460	Blue Cross and Blue Shield of Wyoming	$22,639
00468	Cooperativa De Seguros De Vida De Puerto Rico	$1,765
17120	Blue Cross of California	$2,740
50333	United HealthCare Insurance Company	$172,830
52280	Mutual of Omaha Insurance Company	$1,890,885
Total		$15,828,610

SUMMARY BY CARRIER
Potential Improper Payments

	Carrier	Ambulance	Laboratory	Radiology
00510	Blue Cross and Blue Shield of Alabama	$239,357	$148,939	$106,153
00511	Blue Cross and Blue Shield of Alabama - Georgia	$333,105	$174,413	$129,866
00520	Arkansas Blue Cross and Blue Shield - Arkansas	$91,322	$58,713	$21,673
00521	Arkansas Blue Cross and Blue Shield - New Mexico	$7,143	$14,498	$20,468
00522	Arkansas Blue Cross and Blue Shield - Oklahoma	$36,876	$95,514	$55,867
00523	Arkansas Blue Cross and Blue Shield - Eastern Missouri	$84,370	$150,152	$74,362
00528	Arkansas Blue Cross and Blue Shield - Louisiana	$82,924	$50,731	$46,904
00590	Blue Cross and Blue Shield of Florida, Inc.	$371,998	$892,782	$677,693
00630	AdminaStar Federal, Inc. - Indiana	$176,001	$222,081	$110,720
00650	Blue Cross and Blue Shield of Kansas, Inc. - Kansas	$10,305	$26,145	$23,125
00655	Blue Cross and Blue Shield of Kansas, Inc. - Nebraska	$10,438	$32,928	$14,967
00660	AdminaStar Federal, Inc. - Kentucky	$181,836	$148,596	$36,926
00740	Blue Cross and Blue Shield of Kansas, Inc. - Western Missouri	$42,797	$108,471	$27,234
00751	Blue Cross and Blue Shield of Montana, Inc.	$4,473	$6,106	$9,371
00801	Blue Cross and Blue Shield of Western New York, Inc.	$131,423	$107,579	$109,437
00803	Empire Medicare Services - New York	$617,650	$561,267	$273,870
00805	Empire Medicare Services - New Jersey	$559,805	$386,774	$249,656
00820	Noridian Mutual Insurance Co.- North Dakota	$5,487	$30,749	$21,211
00824	Noridian Mutual Insurance Co. - Colorado	$14,784	$78,283	$33,031
00825	Noridian Mutual Insurance Co. - Wyoming	$3,854	$7,305	$6,507
00826	Noridian Mutual Insurance Co. - Iowa	$15,067	$22,108	$21,924

	Carrier	Ambulance	Laboratory	Radiology
00831	Noridian Mutual Insurance Co. - Alaska	$0	$1,257	$219
00832	Noridian Mutual Insurance Co. - Arizona	$37,359	$201,758	$101,962
00833	Noridian Mutual Insurance Co. - Hawaii	$3,460	$8,643	$1,198
00834	Noridian Mutual Insurance Co. - Nevada	$8,143	$81,926	$34,770
00835	Noridian Mutual Insurance Co. - Oregon	$20,170	$65,008	$35,070
00836	Noridian Mutual Insurance Co. - Washington	$93,695	$146,573	$125,654
00860	Xact Medicare Svcs - New Jersey	$83,306	$73,594	$13,022
00865	Xact Medicare Svcs - Pennsylvania	$1,153,803	$599,206	$350,648
00870	Blue Cross and Blue Shield of Rhode Island	$82,737	$56,043	$23,713
00880	Blue Cross and Blue Shield of South Carolina	$337,364	$44,747	$52,586
00900	Trailblazer's Health Enterprises, LLC - Texas	$1,743,752	$962,355	$338,402
00901	Trailblazer's Health Enterprises, LLC - Maryland	$200,091	$124,546	$126,625
00902	Trailblazer's Health Enterprises, LLC - Delaware	$13,489	$8,780	$28,569
00903	Trailblazer's Health Enterprises, LLC - District of Columbia	$9,401	$143,146	$90,970
00910	Regence Blue Cross and Blue Shield of Utah	$11,738	$52,097	$40,829
00951	Wisconsin Physicians Service Insurance Corp.- Wisconsin	$107,463	$102,461	$86,156
00952	Wisconsin Physicians Service Insurance Corp.- Illinois	$800,463	$678,702	$240,218
00953	Wisconsin Physicians Service Insurance Corp.- Michigan	$369,815	$256,000	$257,921
00973	Triple-S, Inc. - Puerto Rico	$10,146	$8,975	$615
00974	Triple-S, Inc. - Virgin Islands	$192	$709	$0
02050	Transamerica Occidental Life Insurance Co. - California	$771,385	$462,923	$187,624
05130	Connecticut General Life Insurance Co. - Idaho	$4,705	$21,563	$15,660
05440	Connecticut General Life Insurance Co. - Tennessee	$348,027	$99,031	$120,902
05535	Connecticut General Life Insurance Co.- North Carolina	$303,318	$223,117	$137,256

	Carrier	Ambulance	Laboratory	Radiology
10072	United HealthCare Insurance Co. - Railroad Retirement Board	$138,188	$155,207	$93,613
10230	United HealthCare Insurance Company - Connecticut	$548,908	$184,825	$220,603
10240	United HealthCare Insurance Company - Minnesota	$24,168	$50,602	$72,487
10250	United HealthCare Insurance Company - Mississippi	$42,413	$34,592	$17,699
10490	United HealthCare Insurance Company - Virginia	$123,667	$70,463	$84,537
14330	Group Health Inc. - New York	$16,332	$36,243	$35,025
16360	Nationwide Mutual Insurance Co. - Ohio	$651,851	$533,669	$276,239
16510	Nationwide Mutual Insurance Co. - West Virginia	$98,789	$16,908	$26,706
31140	National Heritage Insurance Company - California	$288,227	$264,045	$156,103
31142	National Heritage Insurance Company - Maine	$147,989	$16,542	$36,952
31143	National Heritage Insurance Company - Massachusetts	$1,116,735	$273,306	$340,611
31144	National Heritage Insurance Company - New Hampshire	$33,817	$60,423	$10,708
31145	National Heritage Insurance Company - Vermont	$19,761	$4,031	$2,484
Total		$12,785,882	$9,448,150	$5,855,321

APPENDIX C

SUMMARY BY DURABLE MEDICAL EQUIPMENT REGIONAL CARRIER
Potential Improper Payments

	DMERC	Amount
00635	AdminaStar Federal, Inc.	$769,789
00885	Blue Cross and Blue Shield of South Carolina	$1,481,546
05655	Connecticut General Life Insurance Co.	$781,191
10555	United HealthCare Insurance Co.	$683,195
Total		$3,715,721

COMPUTER APPLICATIONS FOLLOWED IN THE IDENTIFICATION OF POTENTIALLY IMPROPER PAYMENTS FOR CY 1999

We performed a nationwide computer match, using HCFA's National Claims History file, of all SNF PPS stays with discharges in CY 1999 to Part B services rendered by suppliers to SNF residents to identify payments made by Part B to suppliers for services subject to consolidated billing. Of these Part B services, outpatient hospital, ambulance, diagnostic laboratory, radiology (diagnostic, therapeutic, and mammography), and DME were found to be the most vulnerable to noncompliance with consolidated billing. Home health agency services, all other nonphysician Part B services (i.e., therapies, vaccines), and DME claims submitted to other than the DMERCs were not found to represent significant areas of noncompliance.

The population was further refined as follows:

Skilled Nursing Facility Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file
- ✓ Limited population to claims with Date of Admission and Date of Discharge during CY 1999
- ✓ Eliminated claims involving hospital swing beds (Type of Bill 18X)
- ✓ Eliminated $0 paid claims

Outpatient Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated claims with at least one intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims with emergency room revenue center codes 0450 through 0459
- ✓ Eliminated claims with cast room revenue center codes 0700 and 0709
- ✓ Eliminated ESRD claims as identified with revenue center codes 0820 through 0859
- ✓ Eliminated $0 paid claims
- ✓ Eliminated services that were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Laboratory Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated services that have physician involvement
  - ✓ A HCPCS modifier of 26 (professional component); or
  - ✓ Listed in the Carrier Manual, section 15020 as having significant physician involvement for both professional and technical component; or
  - ✓ Subject to the physician fee schedule and has a value greater than zero under the physicians' work RVU.
- ✓ Eliminated services which match an outpatient ESRD claim
- ✓ Eliminated services which match an outpatient emergency room claim
- ✓ Eliminated services which match an outpatient intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Radiology Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated services that have physician involvement
- ✓ Eliminated services which match an outpatient emergency room claim
- ✓ Eliminated services which match an outpatient intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Ambulance Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated services which match an outpatient ESRD claim

- ✓ Eliminated services which match an outpatient emergency room claim - subtracted 1 day from the From Date of Service of the outpatient service to capture "close to midnight" emergencies
- ✓ Eliminated services which match an outpatient intensive service as identified by HCPCS codes listed on Program Memorandum Intermediary Transmittal Number A-98-37
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated services which match outpatient cast room services
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

Durable Medical Equipment Data

- ✓ Extracted paid claims information from the CY 1999 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated $0 paid services
- ✓ Eliminated any purchases with a Place of Service indicating "home"
- ✓ Eliminated any rentals and maintenance/service (HCPC modifiers RR and MS, respectively) with a From Date of Service prior to the Date of SNF Admission
- ✓ Eliminated other DME, prosthetics, orthotics, or vision, with Place of Service indicating "home"
- ✓ Eliminated services rendered on the Day of Admission and the Day of Discharge

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: APR - 2 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: *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)

We appreciate the opportunity to review the above-mentioned OIG draft report concerning the identification of a potential $47.6 million in improper payments made by Medicare for calendar year 1999 for services covered by the consolidated billing provision of the skilled nursing facility (SNF) prospective payment system (PPS). We believe the report provides an important contribution to our efforts to maintain the financial integrity of the Medicare program.

The Health Care Financing Administration (HCFA) detects instances of inappropriate payment on a limited, non-automated, post-payment basis using our program safeguard contractors (PSCs). However, we will be finalizing implementation of an automated process in the near future. The complexity of the systems changes needed to automate the consolidated billing policy, when combined with other necessary critical systems changes, make implementation of an automated system difficult at this time without creating an unacceptable level of risk. In addition to these systems changes, we are in the process of implementing critical systems changes enacted in the Benefits Improvement and Protection Act of 2000 and the Health Insurance Portability and Accountability Act of 1996. While we are dedicated to further refining automation of our consolidated billing systems, we must also protect the integrity of the existing systems by continuing with the aforementioned post-payment pilot strategy until the new systems are operational.

OIG Recommendation

HCFA should establish payment edits within the Common Working File (CWF) and Medicare contractors' claims processing systems to ensure compliance with the SNF consolidated billing provision. The OIG will assist HCFA with this initiative as necessary. Pending the implementation of payment edits, we recommend HCFA adopt interim remedies (recommendations 2-4).

HCFA Response
We concur. HCFA has made meaningful progress towards implementing automated processes for identifying potentially inappropriate payments and recovery of overpayments without unduly burdening providers or exceeding available Medicare contractor resources. However, significant changes in the CWF and within each Medicare contractor's system are necessary to fully automate these processes. Since the scope of these changes necessitates an incremental deployment strategy, we are proceeding accordingly. As we move forward, knowledge gained through interim strategies, such as recovery activities currently underway, will be incorporated into the new systems to refine the edit criteria and enhance the success of the automated processes.

OIG Recommendation
HCFA should continue to work with the OIG to identify and recover improper payments made subsequent to the implementation of the consolidated billing provision. The OIG will provide HCFA with detailed claims information to assist in the recovery process.

HCFA Response
We concur. HCFA is pursuing a risk mitigation strategy using a PSC that supports existing program safeguard activities.

The general elements of this strategy are:

- Immediately tasking the statistical analysis PSC to: (1) identify all SNF and home health PPS episodes of care in three mid-western states; and (2) aggregate all Medicare claims paid within these episodes to determine which claims should not have been paid.

- Tasking the PSC to work with United Government Services and Wisconsin Physicians Service Insurance Corporation (the primary fiscal intermediary (FI) and carrier in the three involved states) and HCFA to: (1) develop mistaken payment reports (including reports on specific providers that appear to be the most aberrant in their billing patterns); and (2) develop methodologies to allow the FIs and carriers to recover mistaken payments via methods that minimize manual intervention.

Based on the results of this three-state activity, HCFA would then develop a strategy to export the three-state findings on a nationwide basis, either through an existing PSC or by issuing a new task order.

OIG Recommendation
HCFA should direct its Medicare contractors to reemphasize education to the Part B suppliers regarding the SNF PPS consolidated billing provision.

HCFA Response

We concur. HCFA recently completed a mandatory training conference for Medicare contractors to discuss the consolidated billing policy and to provide information on upcoming systems changes that will be put in place to prevent duplicate billing. The conference included detailed information on background and policy provisions of the consolidated billing program, and explained proposed systems edits being designed to assist the contractors to identify duplicate billings and recover duplicate payments. These edits are extremely sophisticated as they involve the ability to edit Part A and Part B claims against each other. During the conference, Medicare contractors received detailed information on the edit logic and feedback procedures.

In addition, we have instructed our contractors to schedule consolidated billing training this spring to make sure that their providers/suppliers understand related program requirements and billing procedures. We expect that contractors will then incorporate consolidated billing updates into their ongoing training programs.

OIG Recommendation

HCFA should monitor the Medicare contractors' recovery of the potential $47.6 million of improper payments identified in our review and report recoveries by supplier to OIG for future analysis.

HCFA Response

We concur. HCFA will direct the Medicare FIs and carriers identified in the report to recover the potential $47.6 million in overpayments. When the final report is issued, the OIG will furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the Medicare contractors to initiate and complete recovery action. At that time, we will forward the final report and information needed by the Medicare contractors to effectuate recovery of the overpayments to the regional offices for appropriate action. We will also identify the OIG contact if any questions arise. We appreciate the OIG's offer to provide HCFA with the detailed claims information to assist in the recovery process.

HCFA will need to implement a special monitoring and reporting activity to meet the OIG's request that we report recoveries of overpayments by supplier to the OIG for future analysis. Since this reporting activity will require additional resources for the FIs, HCFA will need to review and determine appropriate funding for this activity in relation to other FI activities. HCFA will need to develop and issue technical instructions for the FIs to track and report recoveries by supplier. HCFA will furnish a semi-annual report to the OIG detailing the progress of the overpayment recoveries by supplier.

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Technical Comments

While we concur with the methodology used for matching the SNF PPS and Part B claims, we suggest two minor clarifications in the methodology section, as follows:

1. Clarify the method by which SNF PPS claims were identified: SNF PPS was being phased in during fiscal year 1999, and the National Claims History File contained bills paid under both PPS and the prior cost reimbursement system. While not explicitly stated, we assumed that the researchers selected Part A claims that included at least one Revenue Code 22, the line item indicating the RUG-III group being billed.

2. Clarify the method used to exclude laboratory and radiology services matching outpatient intensive services identified in program memorandum (PM) A-37-98. The services identified in the PM must be provided in a hospital or critical access hospital (CAH) in order to qualify for exclusion under consolidated billing. The associated laboratory and radiology services are also excluded when billed by the hospital or CAH. It might be preferable to show the radiology and laboratory claims eliminated from the database under the outpatient data section. This would avoid confusion since the services would not be excluded when billed by an independent laboratory or radiology center.