DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 28 2004

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System in Calendar Years 1999 and 2000 (A-01-02-00513)

Attached are two copies of our final report entitled "Review of Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System in Calendar Years 1999 and 2000." We have an interest in this topic because prior Office of Inspector General (OIG) reports have identified the consolidated billing provision of the skilled nursing facility (SNF) prospective payment system (PPS) as a vulnerable area.

The PPS payment rate paid to SNFs for covered Part A stays is intended to cover virtually all costs of furnishing skilled nursing services. Under the SNF PPS consolidated billing provision set forth in sections 1862(a)(18) and 1842(b)(6)(E) of the Social Security Act, an outside supplier must bill and receive payment from the SNF – rather than from Medicare – for services rendered to beneficiaries in a Part A stay.

The primary objective of our review was to determine nationally the extent of improper payments made under Medicare Part B to outside suppliers for services already included in the PPS payment to the SNF. Our secondary objective was to determine the extent to which Part B suppliers billed and were paid by both the SNF and Medicare. The period covered by our review included claims data from Calendar Years 1999 and 2000.

We found the Medicare program often paid twice for the same service - once to the SNF under the Part A prospective payment and again to an outside supplier under Part B. As a result, we identified $108.3 million in improper payments nationwide made under Medicare Part B to suppliers for services already included in the PPS payment that Medicare Part A made to the SNF for a covered stay. In addition, beneficiaries were assessed $33.1 million for coinsurance and deductibles associated with these improper payments.

We identified several causes for improper payments:

- Controls were not established at SNFs or suppliers to prevent improper billing of Medicare for Part B services included in the Part A SNF PPS payment rate.

- The Centers for Medicare & Medicaid Services (CMS) had not yet established edits in its claims processing systems to detect improperly billed Part B services subject to the consolidated billing provision.

Subsequent to the period of our review, CMS established edits in its claims processing systems to detect improperly billed Part B services. These edits match SNF claims against Part B services subject to consolidated billing and for any matches, the Part B services are denied.

Regarding our secondary objective, under the SNF PPS, there is a risk that Part B suppliers will bill and be paid by both Medicare and the SNF. Eleven out of a statistically valid sample of 100 SNF stays we tested involved instances where Part B suppliers billed and were paid by both the SNF and Medicare. We are investigating these cases further.

We recommend CMS:

- recover improper payments
- report completed recoveries of overpayments to OIG
- instruct its contractors to encourage SNFs and suppliers to establish and/or enhance existing billing controls
- identify "best practices" for communicating that SNF residents are in Part A PPS stays and subject to the consolidated billing provision
- continue to provide consolidated billing education and guidance
- delineate the SNFs' responsibility to communicate information regarding residents in Part A PPS stays subject to the consolidated billing provision
- develop data analysis techniques to identify SNFs and suppliers that are repeatedly non-compliant with the consolidated billing provision

CMS concurred with most of these recommendations. However, CMS concurred only in part with our recommendation to instruct its contractors to encourage SNFs and suppliers to establish and/or enhance existing billing controls to ensure compliance with the consolidated billing provision.

Furthermore, CMS did not concur with our original recommendation to report completed recoveries listed by supplier to OIG. CMS believes the costs of reconciling overpayment amounts identified by OIG to amounts based on CMS policy would be resource intensive and cost prohibitive. We have modified this recommendation in our final report to emphasize that we do not expect CMS to reconcile overpayment variances. We continue to believe recovery

data will facilitate our identification of providers that are repeatedly non-compliant with the consolidated billing provision.

Additionally, CMS did not agree with our original recommendation to incorporate language into regulations and CMS guidelines that delineates the SNFs' responsibility to communicate information regarding residents in Part A PPS stays subject to consolidated billing. CMS believes it does not have the authority to mandate the information SNFs must provide to their suppliers. We acknowledge that CMS may lack this authority. Accordingly, we have revised this recommendation in our final report.

If you have any questions or comments about this report, please do not hesitate to call me or have your staff call George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at george.reeb@oig.hhs.gov. Please refer to report number A-01-02-00513 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF IMPROPER PAYMENTS MADE BY MEDICARE PART B FOR SERVICES COVERED UNDER THE PART A SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM IN CALENDAR YEARS 1999 AND 2000

MAY 2004
A-01-02-00513

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act of 1997 provides for a prospective payment system (PPS) payment rate to be paid to skilled nursing facilities (SNF) for covered Part A stays. The Congress intended PPS to cover virtually all costs of furnishing skilled nursing services. Under the SNF PPS consolidated billing provision set forth in sections 1862(a)(18) and 1842(b)(6)(E) of the Social Security Act, an outside supplier must bill and receive payment from the SNF – rather than from Medicare – for services rendered to a beneficiary in a Part A stay. When outside suppliers fail to comply with the consolidated billing provision and bill separately under Part B, Medicare pays twice for the same service - once to the SNF under the prospective payment and a second time under Part B.

The Office of Inspector General (OIG) conducted two previous audits of SNF consolidated billing: "Review of Compliance with the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities (A-01-99-00531)," issued in March 2000, and "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)," issued in June 2001.

OBJECTIVE

The primary objective of our review was to determine nationally the extent of improper payments made under Medicare Part B to outside suppliers for services already included in the PPS payment to the SNF. Our secondary objective was to determine the extent to which Part B suppliers billed and were paid by both the SNF and Medicare.

The period covered by our review included claims data from Calendar Years (CY) 1999 and 2000.

FINDINGS

Improper Payments

We found the Medicare program often paid twice for the same services - once to the SNF under the Part A prospective payment and again to an outside supplier under Part B. Although these services were covered under SNF PPS, outside suppliers billed Medicare directly for the services and were paid by Medicare. Instead, they should have been paid by the SNFs. As a result, we identified $108.3 million in improper payments nationwide made under Medicare Part B to suppliers for services already included in the PPS payment that Medicare Part A made to the SNF for a covered stay. In addition, beneficiaries were assessed $33.1 million for coinsurance and deductibles associated with these improper payments to Part B suppliers.

We previously reported (A-01-00-00538) $40.7 million[1] in improper payments as part of our prior CY 1999 review. Accordingly, to date, our reviews for CYs 1999 and 2000 have identified a total of $149 million in improper payments made under Medicare Part B to outside suppliers for services already included in the SNF PPS payments.

We identified several causes for the improper payments:

- For CYs 1999 and 2000 claims, SNFs and suppliers had not established controls to prevent improper billing of Medicare for Part B services included in the Part A SNF PPS payment rate.

- The Centers for Medicare & Medicaid Services (CMS) had not yet established edits in its claims processing systems to detect improperly billed Part B services subject to the consolidated billing provision.

The consolidated billing edits established by CMS in 2002 were designed to detect and prevent improper payments. In CMS's claims processing systems, these edits match SNF claims against Part B services subject to consolidated billing and for any matches, the Part B services are denied. However, further actions are necessary. Suppliers can bill and be paid by Part B before SNFs submit their PPS claims. Therefore, consolidated billing edits may not be "applied" until the SNF PPS claims are processed. This will result in Part B payments that have to be recouped through offset or collection activities. In order to minimize costly postpayment recovery activities, it is essential that SNFs and suppliers strengthen billing controls to ensure that suppliers bill SNFs, not Medicare, for services subject to the consolidated billing provision.

Part B Suppliers Paid by Both Medicare and SNFs

Additionally, under the SNF PPS, there is a risk Part B suppliers will bill and be paid by both Medicare and the SNF. Eleven out of a statistically valid sample of 100 SNF stays we tested involved instances where Part B suppliers billed and were paid by both the SNF and Medicare (see Appendix B). We are investigating these cases further.

RECOMMENDATIONS

We recommend CMS take the following steps:

- It should initiate, through its Medicare contractors, recovery of the $108.3 million in improper payments identified in this current review as well as the $40.7 million

[1] In this prior review (A-01-00-00538), we identified $47.6 million in improper payments. We have reduced this to $40.7 million to account for improper payments refunded by suppliers since our previous match of CY 1999 data, as well as refinements in our matching methodology. CMS's National Claims History for CY 1999 was incomplete at the time of the prior review. Our current review encompasses the balance of CY 1999 improper payments that were not reported in our previous review, as well as CY 2000 improper payments.

identified in our prior review. In addition, CMS should direct suppliers to return the $33.1 million in coinsurance or deductible payments related to these improper Medicare payments to the appropriate beneficiaries.

- It should report completed recoveries listed by supplier to OIG, so OIG can perform further analysis.

- CMS should instruct its contractors to encourage SNFs and suppliers to establish and/or enhance existing billing controls to ensure compliance with the consolidated billing provision. Such billing controls may include, but are not limited to:

  - timely and accurate communication between SNFs and suppliers regarding SNF residents' Part A status

  - SNF review of supplier bills to ensure that all supplier services provided to residents in Part A stays and subject to consolidated billing are properly billed to the SNF

  - contractual agreements between SNFs and suppliers that incorporate language that specifies compliance responsibilities with regard to proper billing for services subject to the consolidated billing provision

- CMS should work with SNFs, suppliers, Medicare contractors, and other interested parties to identify "best practices" for communicating that SNF residents are in Part A PPS stays and subject to consolidated billing.

- It should also direct fiscal intermediaries (FI) and carriers to continue to provide consolidated billing education and guidance to SNFs and suppliers, with an emphasis on ambulance, hospital outpatient, and globally billed physician services.

- CMS should evaluate possible legislative and other approaches to clearly delineate the SNFs' responsibility to communicate information regarding a resident's Part A status to their suppliers.

- CMS should develop data analysis techniques to identify SNFs and suppliers associated with significant numbers of claims rejected or adjusted by the newly implemented prepayment and postpayment edits. Any SNFs and suppliers that are repeatedly identified as non-compliant with the consolidated billing provision should be subject to appropriate corrective action.

CMS concurred with most of these recommendations. However, CMS concurred only in part with our recommendation to instruct its contractors to encourage SNFs and suppliers to establish and/or enhance existing billing controls to ensure compliance with the consolidated billing provision.

Furthermore, CMS did not concur with our original recommendation to report recoveries listed by supplier to OIG after recoveries are completed so OIG can perform further analysis. CMS believes the costs of reconciling overpayment amounts identified by OIG to overpayment amounts based on CMS policy would be resource intensive and cost prohibitive. We have modified this recommendation in our final report to emphasize that we do not expect CMS to reconcile overpayment variances. We continue to believe recovery data will facilitate our identification of providers that are repeatedly non-compliant with the consolidated billing provision.

Additionally, CMS did not agree with our original recommendation to incorporate language into regulations and CMS guidelines that delineates the SNFs' responsibility to communicate information regarding residents in Part A PPS stays subject to consolidated billing. CMS believes it does not have the authority to mandate the information SNFs must provide to their suppliers. We acknowledge CMS may lack this authority. Accordingly, we have revised this recommendation in our final report.

We have summarized CMS's comments and our responses in the "Recommendations" section of the report. We have also appended CMS's comments, in their entirety, to the report (see Appendix E).

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INTRODUCTION

BACKGROUND

Skilled Nursing Facility Services

Skilled nursing care provided to a Medicare beneficiary is covered by Part A when there is a need for technical or professional personnel such as registered nurses, licensed practical nurses, physical therapists, occupational therapists, and speech therapists or audiologists to manage, observe, and evaluate the beneficiary's care. Medicare covers certain skilled care services that are needed on a daily basis.

Medicare Part A helps pay for up to 100 days of inpatient care in a SNF during a benefit period.[2] After a beneficiary has exhausted his or her allowed days of inpatient SNF coverage under Part A, the beneficiary remains eligible for Medicare Part B benefits.

Medicare's spending for SNF care rose at an average annual rate of 30 percent between 1986 and 1997, making it one of the fastest growing components of the Medicare program. During this period, Medicare paid SNFs based on their reported costs of delivering care. Medicare spent $13 billion for SNF care in 1997.

Prospective Payment System and Consolidated Billing

To address escalating Medicare Part A SNF expenditures, the Balanced Budget Act of 1997 (Public Law 105-33), enacted August 5, 1997, required implementation of a PPS for cost reporting periods beginning on or after July 1, 1998. Medicare no longer reimburses SNFs in accordance with a cost-based system, but rather through per diem, prospective, case-mix adjusted payment rates applicable to all covered SNF services. The Congress intended these payment rates to cover virtually all costs of furnishing skilled nursing services when the beneficiary is in a Part A stay, including the costs of services provided by Part B suppliers.

The PPS payment rate covers virtually all costs of furnishing skilled nursing services; accordingly, under the consolidated billing provision set forth in sections 1862(a)(18) and 1842(b)(6)(E) of the Social Security Act, the SNF is responsible for billing Medicare for most of the services rendered to its residents in a Medicare Part A stay. SNFs must furnish services either directly or under arrangements with outside suppliers. The outside suppliers must then bill the SNF for the services rendered.

Prior Reviews of SNF Consolidated Billing

OIG conducted two previous audits of SNF consolidated billing: "Review of Compliance with the Consolidated Billing Provision Under the Prospective Payment System for

[2] 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 provides skilled nursing or rehabilitation services for 60 days in a row.

Skilled Nursing Facilities (A-01-99-00531)" and "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)." These reports are published on our Web site at http://oig.hhs.gov.

OBJECTIVES, SCOPE, AND METHODOLOGY

Objectives

The primary objective of our review was to determine nationally the extent of improper payments made under Medicare Part B to outside suppliers for services already included in the PPS payment to the SNF. Our secondary objective was to determine the extent to which Part B suppliers billed and were paid by both the SNF and Medicare.

Scope

The period covered by our review is CYs 1999 and 2000. In our previous review (A-01-00-00538), we identified $40.7 million (see Footnote 4, page 4) in improper payments made to suppliers for services subject to consolidated billing; however, CMS's National Claims History for CY 1999 was incomplete at that time. Our current review encompasses the balance of CY 1999 improper payments that were not reported in our previous review, as well as CY 2000 improper payments.

The objective of our review did not require an understanding or assessment of the complete internal control structure at CMS or its contractors. Therefore, we limited consideration of the internal control structure to the payment controls in place within the Common Working File (CWF) and selected Medicare contractors' Part A and Part B claims processing systems to ensure compliance with the consolidated billing provision.

Our prior 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)," included improper Part B payments for durable medical equipment (DME) subject to the consolidated billing provision. Because of the many issues unique to DME, we did not include DME services in this review. Accordingly, we will perform a separate review of payments for DME services provided to beneficiaries in Part A SNF stays. We will issue a separate report upon completion of that review.

Methodology to Determine Extent of Improper Part B Payments

To determine the extent of improper Medicare Part B payments to outside suppliers for services already included in the Part A PPS payment, we took the following steps:

- We reviewed applicable Medicare laws and regulations.

- We performed a computer match of CYs 1999 and 2000 SNF PPS claims to Part B services rendered by suppliers to SNF residents nationwide (see Appendix A for our computer match methodology).

- We used the results of the computer match to identify the total sum of improper payments.

- We selected 27 claims for Part B services from the computer match in order to validate the results of the match and to identify control weaknesses contributing to noncompliance with the consolidated billing provision. These claims represented services rendered by 5 different suppliers while the beneficiaries were in SNF PPS stays. We met with representatives of the 5 SNFs and 5 Part B suppliers to discuss the 27 selected claims.

- We reviewed the available CWF Part B and outpatient summary records and detail claim history for the selected claims to confirm that Medicare made separate payments to suppliers for services that were already reimbursed to the SNF through the PPS.

- We contacted CMS officials to follow up on the status of actions taken on the recommendations made as a result of our prior reviews.

In completing our review, we established reasonable assurance that the data was authentic and accurate. Our audit was not directed toward assessing the completeness of the file from which the data was obtained. We did not extend our audit work related to validation of the computer match beyond the 27 claims because, in our professional judgment, additional audit work would not have produced different results. We base this conclusion on the results of our review of the 27 claims, as well as the results of our 2 prior reviews in this area.

We conducted our review at selected SNFs and Part B suppliers in Massachusetts, Rhode Island, and Connecticut.

Methodology to Determine Extent to Which Suppliers Billed Both SNF and Part B

The secondary objective of our review was to determine the extent to which Part B suppliers billed and were paid by both the SNF and Medicare. To accomplish this objective, we selected a statistical sample of 100 SNF PPS stays from our population of 886,554 stays and identified all the services rendered during the stays that resulted in improper Part B payments to suppliers. SNF stays were selected using a simple random sample. Details of our sampling methodology are presented in Appendix B. We contacted each of the SNFs associated with the selected SNF stays and requested that the SNFs:

- review all services rendered during the selected SNF stays that resulted in improper Part B payments made to suppliers

- identify those services which were billed to and paid by the SNF
- provide documentary evidence of billing and payment

Our review was made in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Under the SNF PPS consolidated billing provision, an outside supplier must submit a bill to the SNF and receive payment from the SNF for services rendered to a beneficiary in a Part A stay.

We identified $108.3 million in improper payments made under Medicare Part B to suppliers for services already included in the PPS payment Part A made to the SNF.[3] As a result, the Medicare program paid twice for the same service - once to the SNF under the Part A prospective payment and again to an outside supplier under Part B. Although these services were covered under SNF PPS, outside suppliers billed Medicare directly for the services and were paid by Medicare. Instead, they should have been paid by the SNFs. In addition, beneficiaries were assessed $33.1 million for coinsurance and deductibles associated with these improper payments. These improper payments were made because adequate controls were not established at the time to preclude separate payment for Part B services.

The $108.3 million in improper payments identified as a result of this review are in addition to the $40.7 million in improper payments identified as part of our previous review of CY 1999 payments.[4] Accordingly, to date, our reviews of CYs 1999 and 2000 have identified a total of $149 million in improper payments made under Medicare Part B to outside suppliers for services included in the SNF PPS payment. It is important to note the $149 million in improper payments developed through the computer match is an amount that represents total provider-specific overpayments, not an amount based on a statistical projection of sample results.

We also found instances where suppliers billed and were paid by both the SNF and Part B. Based on our statistically valid sample, we found 11 of the 100 SNF stays we tested involved instances where Part B suppliers billed and were paid by both the SNF and Medicare (see Appendix B).

[3] We acknowledge that some Part B suppliers may have identified and subsequently refunded improper payments and that those refunds may not be reflected in the data used to perform our computer match.

[4] In this prior review (A-01-00-00538), we identified $47.6 million in improper payments. We have reduced this to $40.7 million to account for improper payments refunded by suppliers since our previous match of CY 1999 data, as well as refinements in our matching methodology.

We contacted CMS officials to follow up on the status of actions taken on the recommendations made as a result of our prior reviews. According to officials at CMS, action has not yet been taken to collect the $40.7 million in improper payments identified in our prior review. As we agreed with CMS officials, after issuing the final report for this review, OIG will consolidate the overpayments identified in this current review and in our prior review. We will provide CMS with detailed claims information to assist in the recovery process. In addition, based on our audit work, we acknowledge that, as we previously recommended, CMS established payment edits in CY 2002 within its claims processing systems to ensure compliance with the SNF consolidated billing provision.

IMPROPER PAYMENTS CONTINUE UNDER CONSOLIDATED BILLING

Based on the results of our computer match and subsequent fieldwork to validate the match, we found that during CYs 1999 and 2000, Medicare Part B made $108.3 million in improper payments nationwide. The following services are most vulnerable to improper payments: outpatient hospital department services, ambulance, laboratory, and radiology.

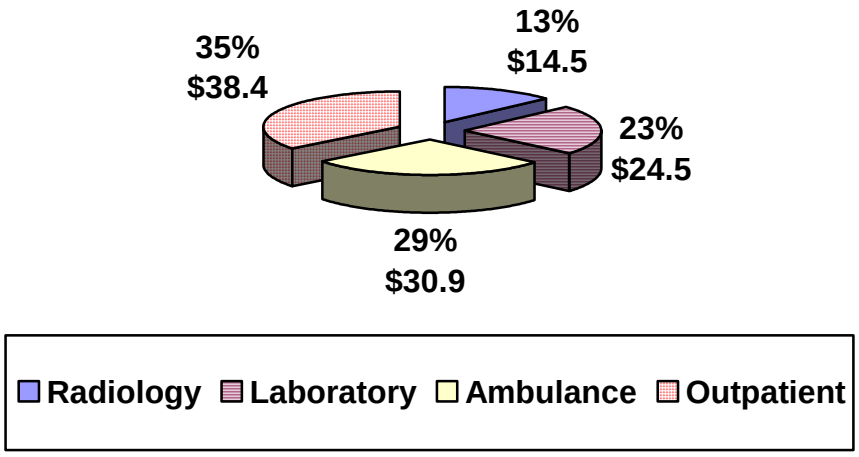

Figure 1 – Nationwide Part B Improper Payments for CYs 1999 and 2000 (in millions)

The $108.3 million in improper payments identified as a result of this review are in addition to the $40.7 million in improper payments identified as part of our previous review of CY 1999 payments.

BILLING AND PAYMENT CONTROLS NOT ESTABLISHED

For CYs 1999 and 2000, adequate controls had not been established at SNFs or suppliers to prevent improper billing of Medicare for Part B services included in the Part A SNF PPS payment rate. Based on discussions with selected providers and suppliers, we found SNFs and suppliers:

- were unaware of the consolidated billing provision and the need for controls

- were cognizant of the consolidated billing provision but did not establish controls

- did not adhere to the controls they had established to comply with the consolidated billing provision

Furthermore, during the period of our review, Medicare did not prevent these improper payments because CMS had not yet established adequate controls to detect improperly billed Part B services included in the SNF PPS payment rate and subject to the consolidated billing provision. CMS delayed implementation of consolidated billing edits because of the significant resources required to ensure CMS and its contractors were "Year 2000" compliant. Additionally, CMS needed to make major changes necessary to accommodate the edits in the CWF and each Medicare contractors' claims processing system. CMS began implementing edits to detect and prevent improperly billed Part B services in its claims processing systems in 2002. In CMS's claims processing systems, these edits match SNF claims against Part B services subject to consolidated billing and for any matches, the Part B services are denied.

Although CMS has established edits, further actions are necessary. Suppliers can bill and be paid by Part B before the SNFs submit their PPS claims. Therefore, edits may not be "applied" until SNF PPS claims are processed by the system. This will result in Part B payments that have to be recouped through offset or collection activities. In order to minimize costly postpayment recovery activities, it is essential SNFs and suppliers strengthen billing controls to ensure that the SNF is billed for services subject to the consolidated billing provision.

Billing Controls Established Subsequent to Period of Review

As part of this review, we met with five SNFs and five suppliers to identify specific control weaknesses contributing to noncompliance with the consolidated billing provision. We also discussed control procedures established by the SNFs and suppliers subsequent to the period covered by our review. We found:

- SNFs and suppliers acknowledge that timely and accurate communications between the SNFs and their suppliers regarding a resident's Medicare Part A status are critical in order to ensure proper billing for services subject to the consolidated billing provision. SNFs and suppliers currently employ a variety of methods to communicate this information. For example, some SNFs provide suppliers with monthly census data that identify residents in Part A stays; in other instances, suppliers send SNFs lists of services provided so the SNF can identify those services rendered to Part A residents. In some cases, communications are verbal, with information exchanged telephonically.

- Two suppliers advised us they have changed their billing cycles to accommodate consolidated billing. These suppliers are billing on a weekly, biweekly, and even monthly basis in order to ensure they have the information they need to bill correctly.

- Two SNFs advised us they are now reviewing supplier bills to ensure the SNF is billed for services provided to Part A residents.

- Two SNFs and 3 suppliers stated their supplier contracts now incorporate language that specifies compliance responsibilities with regard to proper billing for services subject to the consolidated billing provision.

Although SNFs and suppliers have acknowledged the need for control procedures and have recently taken steps to implement such procedures, the SNFs and suppliers we met with recognize additional measures can be taken to ensure compliance with the consolidated billing provision. For example, SNFs and suppliers are currently using several forms of communication to relay and obtain information regarding residents in Part A PPS stays. Such an informal system is not reliable because there is no consistent means of communication. We also found some SNFs and suppliers appear confused about consolidated billing, particularly as it relates to ambulance, hospital outpatient, and globally billed physician services.

Based on the results of our review, we do not believe the objectives of the consolidated billing provision can be achieved without formal recognition of the SNFs' responsibility to communicate timely and accurate information concerning residents in Part A PPS stays subject to consolidated billing. In this regard, suppliers must rely upon information from the SNFs in order to determine the appropriate party to bill for services provided to SNF residents. The logic behind the consolidated billing edits makes it clear that it is incumbent upon the suppliers to recognize their obligation to bill correctly--if a Part B supplier submits a Medicare claim for services that are subject to the consolidated billing provision because they were provided during a resident's Part A PPS stay, the Part B claim is rejected or adjusted. However, the edit process is unable to detect whether or not the SNF provided the supplier with the information necessary to bill correctly. Without formal recognition of their responsibility, SNFs have little incentive to establish controls to ensure the timely and accurate communication of billing information to their suppliers.

PART B SUPPLIERS PAID BY MEDICARE AND SNFS

Under the SNF PPS, there is a risk that Part B suppliers will bill and be paid by both Medicare and the SNF. Eleven out of a statistically valid sample of 100 SNF stays we tested involved instances where Part B suppliers billed and were paid by both the SNF and Medicare. We are continuing to review these cases.

RECOMMENDATIONS

OIG's Recommendation 1

CMS should initiate, through its Medicare contractors, recovery of the $108.3 million in improper payments identified in this current review as well as the $40.7 million identified in our prior review. In addition, CMS should direct suppliers to return coinsurance or deductible payments related to these improper Medicare payments to the appropriate beneficiaries.

CMS's Comment

CMS concurred with this recommendation, and stated it will issue overpayment instructions to its Medicare contractors after review of the OIG's final report and associated files.

Additional OIG Comment

After issuing the final report for this review, OIG will consolidate the overpayments identified in both reviews and provide CMS with detailed claims information to assist in the recovery process.

OIG's Recommendation 2

CMS should report completed recoveries listed by supplier to OIG, so OIG can perform further analysis.

CMS's Comment

CMS did not concur with this recommendation as written in our draft report. Since the overpayment amounts identified by OIG and the overpayment amounts based on CMS policy may vary, CMS believes the costs of instituting a tracking tool for reconciling these amounts would be resource intensive and cost prohibitive.

OIG's Response

We acknowledge probable variances between overpayment amounts identified by OIG and actual overpayment amounts based on CMS policy instructions and guidance. Accordingly, we have modified our recommendation to state that we do not expect CMS or its Medicare contractors to reconcile overpayment variances. However, we would like to obtain the subsequent recovery amounts by supplier to facilitate our identification of those suppliers that are repeatedly non-compliant with the consolidated billing provision.

OIG's Recommendation 3

CMS should instruct its contractors to encourage SNFs and suppliers to establish and/or enhance existing billing controls to ensure compliance with the consolidated billing provision. Such billing controls may include, but are not limited to:

- timely and accurate communication between SNFs and suppliers regarding SNF residents' Part A status

- SNF review of supplier bills to ensure that all supplier services provided to residents in Part A stays and subject to consolidated billing are properly billed to the SNF

- contractual agreements between SNFs and suppliers that incorporate language that specifies compliance responsibilities with regard to proper billing for services subject to consolidated billing

CMS's Comment

CMS concurred in part with the general recommendation. In this regard, it has tasked one of its program safeguard contractors to conduct an analysis of the effect of the consolidated billing provision on improper billing to Medicare contractors. Based on the results of this analysis, CMS may develop systematic approaches to address improper payments. However, CMS did not concur with specific recommendations regarding billing controls. CMS believes there is no reason SNFs need to review bills that suppliers are sending to the Medicare carrier for payment. In addition, CMS believes it is not able to mandate the language to include in a contract that a SNF has with a supplier.

OIG's Response

Our recommendation was not intended to convey that SNFs should review supplier bills sent to Medicare Part B. More clearly stated, our recommendation is that SNFs should review supplier bills submitted to the SNFs to ensure that all supplier services provided to residents in Part A stays and subject to consolidated billing are properly billed to the SNF.

Additionally, we did not intend to suggest that CMS mandate language for SNFs and suppliers to use in contractual agreements for supplier services. We believe CMS and its contractors should encourage SNFs and suppliers to recognize compliance responsibilities regarding the consolidated billing provision in their contract service agreements.

OIG's Recommendation 4

CMS should work with SNFs, suppliers, Medicare contractors, and other interested parties to identify "best practices" for communicating that SNF residents are in Part A PPS stays and subject to consolidated billing.

CMS's Comment

CMS concurred with this recommendation.

OIG's Recommendation 5

Direct FIs and carriers to continue to provide consolidated billing education and guidance to SNFs and suppliers, with an emphasis on ambulance, hospital outpatient, and globally billed physician services.

CMS's Comment

CMS concurred with this recommendation.

OIG's Recommendation 6

Evaluate possible legislative and other approaches to clearly delineate the SNFs' responsibility to communicate information regarding a resident's Part A status to their suppliers.

CMS's Comment

CMS does not concur with this recommendation as originally written. CMS believes it does not have the authority to mandate the information SNFs must provide to their suppliers. CMS also requests that the OIG report explicitly acknowledge that CMS lacks the authority to mandate this type of activity.

OIG's Response

We agree that CMS does not have the authority to implement the recommendation included in our draft report and have modified our sixth recommendation accordingly.

OIG's Recommendation 7

CMS should develop data analysis techniques to identify SNFs and suppliers associated with significant numbers of claims rejected or adjusted by the newly implemented prepayment and postpayment edits. Any SNFs and suppliers repeatedly identified as non-compliant with the consolidated billing provision should be subject to appropriate corrective action.

CMS's Comment

CMS agreed to consider this recommendation. As CMS continues to refine its edits, it will consider developing data analysis techniques to identify SNFs and suppliers that are repeatedly non-compliant with the consolidated billing provision.

APPENDICES

COMPUTER APPLICATIONS FOLLOWED IN THE IDENTIFICATION OF IMPROPER PAYMENTS

Skilled Nursing Facility Data

- ✓ Extracted paid claims information from the CYs 1999 and 2000 National Claims History file
- ✓ Limited population to claims with revenue center code 0022 denoting PPS payment
- ✓ Eliminated claims involving hospital swing beds (Type of Bill 18X)
- ✓ Eliminated $0 paid claims
- ✓ Eliminated claims for health maintenance organization enrollees

Outpatient Data

- ✓ Extracted paid claims information from the CYs 1999 and 2000 National Claims History file based on the beneficiary health insurance claim (HIC) numbers from the SNF paid claims data
- ✓ Eliminated claims with at least one intensive service as identified by HCPCS codes listed on Program Memoranda Transmittal Numbers A-98-37, A-00-1, and AB-00-18
- ✓ Eliminated claims with emergency room revenue center codes 0450 through 0459
- ✓ Eliminated end stage renal disease (ESRD) claims as identified with revenue center codes 0800 through 0809, 0820 through 0859, 0880 through 0889, or a Type of Bill 72X
- ✓ Eliminated dialysis-related EPO claims as identified with revenue center codes 0634 and 0635 and a primary diagnosis code of renal disease
- ✓ Eliminated claims with Medicare preventive services as identified by HCPCS codes listed on Program Memorandum Transmittal Number AB-01-158
- ✓ Eliminated claims with $0 Medicare payment, $0 coinsurance, and $0 deductible
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated claims for ambulance services as identified by revenue center codes 0540 through 0549
- ✓ Eliminated claims for cast room services as identified by revenue center codes 0700 and 0709
- ✓ Eliminated any claims for radioisotope services, chemotherapy, and customized prosthetic devices as identified on Program Memorandum Transmittal Number AB-00-18 effective for dates of service on or after April 1, 2000
- ✓ Eliminated claims for services rendered on the Day of Admission
- ✓ Eliminated claims for services on Day of Discharge if patient status did not indicate transfer to another SNF

Laboratory Data

- ✓ Extracted paid claims information from the CYs 1999 and 2000 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated any service with a "26" HCPCS modifier indicating professional component
- ✓ Eliminated services which match an outpatient ESRD claim
- ✓ Eliminated any dialysis-related EPO services as identified by HCPCS codes Q9920 through Q9940 and a primary diagnosis code of renal disease
- ✓ Eliminated Medicare preventive services as identified by HCPCS codes listed on Program Memorandum Transmittal Number AB-01-158
- ✓ Eliminated emergency room services as identified by place of service code 23
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated services with $0 Medicare payment, $0 coinsurance, and $0 deductible
- ✓ Eliminated services that have physician involvement as identified by the professional component/technical component indicator field of the National Physician Fee Schedule Relative Value File
- ✓ Eliminated services rendered on the Day of Admission
- ✓ Eliminated any claims for radioisotope services, chemotherapy, and customized prosthetic devices as identified on Program Memorandum Transmittal Number AB-00-18 effective for dates of service on or after April 1, 2000
- ✓ Eliminated services on Day of Discharge if patient status did not indicate transfer to another SNF

Radiology Data

- ✓ Extracted paid claims information from the CYs 1999 and 2000 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated any service with a "26" HCPCS modifier indicating professional component
- ✓ Eliminated any dialysis-related EPO services as identified by HCPCS codes Q9920 through Q9940 and a primary diagnosis code of renal disease
- ✓ Eliminated Medicare preventive services as identified by HCPCS codes listed on Program Memorandum Transmittal Number AB-01-158
- ✓ Eliminated emergency room services as identified by place of service code 23
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated services with $0 Medicare payment, $0 coinsurance, and $0 deductible
- ✓ Eliminated services that have physician involvement as identified by the professional component/technical component indicator field of the National Physician Fee Schedule Relative Value File

- ✓ Eliminated any claims for radioisotope services, chemotherapy, and customized prosthetic devices as identified on Program Memorandum Transmittal Number AB-00-18 effective for dates of service on or after April 1, 2000
- ✓ Eliminated services rendered on the Day of Admission
- ✓ Eliminated services on Day of Discharge if patient status did not indicate transfer to another SNF

Ambulance Data

- ✓ Extracted paid claims information from the CYs 1999 and 2000 National Claims History file based on the beneficiary HIC numbers from the SNF paid claims data
- ✓ Eliminated services on or after April 1, 2000 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 Memoranda Transmittal Numbers A-98-37, A-00-1, and AB-00-18
- ✓ Eliminated claims where the services were rendered during the non-covered portion of the SNF stay
- ✓ Eliminated services with $0 Medicare payment, $0 coinsurance, and $0 deductible
- ✓ Eliminated services which match outpatient cast room services
- ✓ Eliminated services that have physician involvement as identified by the professional component/technical component indicator field of the National Physician Fee Schedule Relative Value File
- ✓ Eliminated services rendered on the Day of Admission
- ✓ Eliminated services on Day of Discharge if patient status did not indicate transfer to another SNF

APPENDIX B

RESULTS OF STATISTICAL SAMPLE

We used a simple random sample of 100 SNF stays out of a population of 886,554 SNF stays. The results of our projection at the 90 percent confidence level are shown below.

Sample Size	100
Value of Sample	$11,126
Number of Errors	11
Value of Errors	$1,368.27
Population Size	886,554
Value of Population	$108.3 million

Point Estimate	$12,130,452
Confidence Level	@ 90%
Lower Confidence Level	$2,494,580
Upper Confidence Level	$21,766,325
Sample Precision	+/-79.44%

SUMMARY BY FISCAL INTERMEDIARY

Improper Payments

Fiscal Intermediary		Amount
00010	Blue Cross and Blue Shield of Alabama	$333,926.62
00011	Cahaba Government Benefit Administrator - Iowa	255,059.35
00020	Arkansas Blue Cross and Blue Shield - Arkansas	282,176.08
00030	Blue Cross and Blue Shield of Arizona, Inc.	281,806.56
00040	Blue Cross of California	1,049,206.14
00060	Anthem Insurance Companies, Inc. - Connecticut	94,044.36
00090	Blue Cross and Blue Shield of Florida, Inc.	2,841,155.94
00101	Blue Cross and Blue Shield of Georgia, Inc.	477,390.29
00130	Anthem Insurance Companies, Inc. - Indiana	1,165,110.72
00131	Anthem Insurance Companies, Inc. - Illinois	1,222,362.34
00140	Wellmark,Inc. - Iowa	230,630.10
00150	Blue Cross and Blue Shield of Kansas, Inc.	356,867.62
00160	Anthem Insurance Companies, Inc. - Kentucky	579,775.41
00180	Associated Hospital Service of Maine - Maine	285,760.19
00181	Associated Hospital Service of Maine - Massachusetts	1,562,369.11
00190	Blue Cross and Blue Shield of Maryland, Inc.	1,587,588.64
00220	Noridian Mutual Insurance Company - Minnesota	133,094.80
00230	Blue Cross and Blue Shield of Mississippi	651,952.60
00250	Blue Cross and Blue Shield of Montana, Inc.	160,987.09
00260	Blue Cross and Blue Shield of Nebraska	141,292.03
00270	Blue Cross and Blue Shield of New Hampshire	222,157.08
00280	Horizon Blue Cross and Blue Shield of New Jersey, Inc.	530,918.39
00308	Empire Medicare Services	3,431,088.98
00310	Blue Cross and Blue Shield of North Carolina	606,658.18
00320	Noridian Mutual Insurance Company - North Dakota	1,106,044.60
00332	Anthem Insurance Companies, Inc. - Ohio	1,901,140.58
00340	Blue Cross and Blue Shield of Oklahoma	217,775.00

	Fiscal Intermediary	Amount
00350	Blue Cross and Blue Shield of Oregon	$417,523.89
00363	Veritus Medicare Services	2,241,185.18
00370	Blue Cross and Blue Shield of Rhode Island	201,918.86
00380	Palmetto Government Benefits Administrators	288,062.06
00382	Blue Cross and Blue Shield of South Carolina	5,238.52
00390	Riverbend Government Benefits Administrator	2,373,313.12
00400	Trailblazers Health Enterprises, LLC	2,044,181.29
00410	Regence Blue Cross and Blue Shield of Utah	190,440.48
00423	United Government Services - Virginia	128,692.92
00430	Premera Blue Cross	539,033.92
00450	United Government Services - Wisconsin	1,711,694.71
00452	United Government Services - Michigan	1,088,919.19
00453	United Government Services - West Virginia	916,883.31
00454	United Government Services - California	315,407.64
00460	Blue Cross and Blue Shield of Wyoming	52,812.52
00468	Cooperativa De Seguros De Vida De Puerto Rico	4,873.45
17120	Blue Cross of California - Hawaii	1,895.01
50333	United Health Care Insurance Company	358,562.93
52280	Mutual of Omaha Insurance Company	3,800,197.81
Total		**$38,389,175.61**

SUMMARY BY CARRIER
Improper Payments

	Carrier	Ambulance	Radiology	Laboratory
00510	Blue Cross and Blue Shield of Alabama	$511,708.64	$284,255.14	$456,525.09
00511	Blue Cross and Blue Shield of Alabama - Georgia	809,291.93	302,416.22	443,962.81
00512	Alabama Blue Shield - Mississippi	41,591.63	23,832.82	39,762.55
00520	Arkansas Blue Cross and Blue Shield - Arkansas	466,883.34	39,083.87	151,867.13
00521	Arkansas Blue Cross and Blue Shield - New Mexico	29,513.27	39,860.59	48,713.07
00522	Arkansas Blue Cross and Blue Shield - Oklahoma	103,157.05	103,348.96	224,084.44
00523	Arkansas Blue Cross and Blue Shield - East Missouri	291,511.95	190,415.10	427,123.01
00528	Arkansas Blue Cross and Blue Shield - Louisiana	346,301.11	150,266.34	179,872.04
00590	Blue Cross and Blue Shield of Florida, Inc.	994,123.61	1,419,368.48	1,956,515.81
00591	First Coast - Connecticut	267,564.32	259,740.81	118,332.20
00630	Adminastar Federal, Inc. - Indiana	540,675.18	314,572.37	709,593.25
00650	Blue Cross and Blue Shield of Kansas, Inc. - Kansas	42,706.67	60,677.65	64,425.89
00655	Blue Cross and Blue Shield of Kansas, Inc. - Nebraska	43,819.72	38,996.42	91,896.25
00660	Adminastar Federal, Inc. - Kentucky	573,649.55	121,117.66	524,333.80
00740	Blue Cross and Blue Shield of Kansas, Inc. - Western Missouri	158,166.84	54,147.79	263,189.89
00751	Blue Cross and Blue Shield of Montana, Inc.	11,050.85	17,698.14	10,674.19
00801	Blue Cross and Blue Shield of Western New York	343,585.90	435,775.06	344,213.88
00803	Empire Medicare Services - New York	1,844,027.21	853,967.53	1,454,847.20
00805	Empire Medicare Services - New Jersey	1,421,484.21	844,059.20	1,036,028.36
00820	Noridian Mutual Insurance Company - North Dakota	20,757.09	61,696.65	124,203.55
00824	Noridian Mutual Insurance Company - Colorado	67,236.21	71,549.73	125,895.93

	Carrier	Ambulance	Radiology	Laboratory
00825	Noridian Mutual Insurance Company - Wyoming	$7,858.08	$18,426.28	$32,819.95
00826	Noridian Mutual Insurance Company - Iowa	48,437.17	55,042.78	73,721.60
00831	Noridian Mutual Insurance Company - Alaska	2,313.33	4,338.84	2,075.90
00832	Noridian Mutual Insurance Company - Arizona	99,065.77	232,104.38	365,362.85
00833	Noridian Mutual Insurance Company - Hawaii	6,885.30	5,458.51	29,305.44
00834	Noridian Mutual Insurance Company - Nevada	12,213.83	71,909.72	130,639.74
00835	Noridian Mutual Insurance Company - Oregon	44,452.73	55,090.58	115,275.70
00836	Noridian Mutual Insurance Company - Washington	258,150.80	276,353.63	320,043.80
00860	Xact Medicare Services - New Jersey	22,644.12	4,186.23	25,174.01
00865	Xact Medicare Services - Pennsylvania	2,634,335.57	782,798.21	1,894,965.17
00870	Blue Cross and Blue Shield of Rhode Island	$291,499.31	$75,568.34	$148,550.00
00880	Blue Cross and Blue Shield of South Carolina	606,570.90	92,163.45	123,222.36
00882	Palmetto Government Benefits Administrators	145,637.41	113,628.24	159,333.24
00900	Trailblazers Health Enterprises, LLC - Texas	2,853,520.72	851,785.34	2,499,652.83
00901	Trailblazers Health Enterprises, LLC - Maryland	327,987.75	270,241.14	234,320.09
00902	Trailblazers Health Enterprises, LLC - Delaware	71,848.81	66,427.33	40,824.09
00903	Trailblazers Health Enterprises, LLC - District of Columbia	13,777.86	202,172.89	266,398.89
00904	Trailblazers Health Enterprises, LLC - Virginia	78,262.97	64,647.77	45,248.48
00910	Regence Blue Cross and Blue Shield of Utah	43,024.15	48,042.81	127,054.29
00951	Wisconsin Physicians Service Insurance Corporation - Wisconsin	332,211.68	269,393.50	327,504.54
00952	Wisconsin Physicians Service Insurance Corporation - Illinois	1,551,072.12	617,173.85	1,829,833.47
00953	Wisconsin Physicians Service Insurance Corporation - Michigan	582,252.62	582,984.05	657,654.85
00954	Wisconsin Physicians Service Insurance Corporation - Minnesota	17,075.81	57,880.25	45,134.48
00973	Triple-S, Inc. - Puerto Rico	14,067.60	2,647.78	5,418.87
00974	Triple-S, Inc. - Virgin Islands	651.60	374.93	715.19

	Carrier	Ambulance	Radiology	Laboratory
02050	Transamerica Occidental Life Insurance Company - California	2,452,057.20	266,344.28	859,632.04
05130	Connecticut General Life Insurance Company - Idaho	$16,345.45	$52,848.68	$48,485.27
05440	Connecticut General Life Insurance Company - Tennessee	598,856.12	205,575.86	277,743.82
05535	Connecticut General Life Insurance Company - North Carolina	903,228.40	344,430.80	669,872.91
10072	United Health Care Insurance Company - Railroad Retirement Board	252,674.32	163,811.38	303,256.38
10230	United Health Care Insurance Company - Connecticut	961,559.09	433,493.53	360,351.07
10240	United Health Care Insurance Company - Minnesota	45,355.32	161,038.71	144,319.82
10250	United Health Care Insurance Company - Mississippi	134,276.63	45,551.99	105,509.53
10490	United Health Care Insurance Company - Virginia	215,355.73	125,869.45	134,481.39
14330	Group Health Incorporated	47,156.85	96,313.95	94,925.37
16360	Nationwide Mutual Insurance Company - Ohio	1,830,224.26	802,782.31	1,604,889.00
16510	Nationwide Mutual Insurance Company - West Virginia	277,535.63	78,956.67	60,559.41
31140	National Heritage Insurance Company - California	788,558.69	275,044.30	541,636.36
31142	National Heritage Insurance Company - Maine	196,691.59	81,740.68	34,598.11
31143	National Heritage Insurance Company - Massachussetts	2,660,055.76	774,559.96	705,148.47
31144	National Heritage Insurance Company - New Hampshire	123,882.14	24,868.98	127,570.93
31145	National Heritage Insurance Company - Vermont	77,820.84	7,989.35	11,347.34
31146	National Heritage Insurance Company - Southern California	370,087.78	52,812.90	160,549.54
Total		**$30,946,346.09**	**$14,501,721.14**	**$24,541,186.92**

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: AUG - 8 2003

TO: Dara Corrigan
Acting Principal Deputy Inspector General
Office of Inspector General

FROM: Thomas A. Scully
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of 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 in Calendar Years 1999 and 2000" (A-01-02-00513)

Thank you for the opportunity to review and comment on the above-referenced draft report which reviews the potential improper payments made by Medicare Part B for services covered under the Part A skilled nursing facility (SNF) prospective payment system (PPS) in calendar years 1999 and 2000. According to OIG, a potential $108.3 million in improper payments were 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. In addition to these improper payments, the beneficiaries of these services may have incurred unnecessary charges of $33.1 million in coinsurance and deductibles.

The Centers for Medicare & Medicaid Services (CMS) appreciates the effort that went into this report. Our detailed comments to the specific recommendations are outlined below.

OIG Recommendation

Initiate, through its Medicare contractors, recovery of the potential $108.3 million in potential improper payments identified in this current review as well as the $47.6 million identified in our prior review. Subsequent to issuance of the final report for this review, OIG will consolidate the overpayments identified in both reviews and provide CMS with detailed claims information to assist in the recovery process. In addition, CMS should direct suppliers to return coinsurance or deductible payments related to these improper Medicare payments to the appropriate beneficiaries.

CMS Response

After review of the OIG's final report and associated files, CMS will issue appropriate overpayment instructions to the Medicare contractors.

OIG Recommendation
Report recoveries by suppliers to OIG after recoveries are completed, so OIG can perform further analysis.

CMS Response
Using OIG findings and workpapers, CMS instructs Medicare contractors to determine the actual amount of the overpayment based on CMS policy instructions and guidance. These amounts may vary from those amounts determined by OIG. Instituting a tracking tool that would reconcile the amounts as reported by OIG and those as determined by the Medicare contractor on an individual overpayment and then aggregated across all contractors would be a cost to the Medicare contractors and resource intensive for CMS. The CMS believes that the costs involved in doing this outweigh any benefits.

OIG Recommendation
Instruct its contractors to encourage SNFs and suppliers to establish and/or enhance existing billing controls to ensure compliance with the consolidated billing provision. Such billing controls should include, but are not limited to:

- Timely and accurate communication between SNFs and suppliers regarding SNF residents' payer status;

- SNF review of supplier bills to ensure that all supplier services provided to residents in Part A stays and subject to consolidated billing are properly billed to the SNF; and

- Language in contractual agreements that specifies compliance responsibilities with regard to proper billing for services subject to the consolidated billing provision.

CMS Response
We believe there is no reason SNFs need to review bills that suppliers are sending to the Medicare carrier for payment. We do not believe that CMS can require SNFs to take on the burden of reviewing another entity's bills. Currently, there are no statutory or regulatory requirements mandating that SNFs review Part B Medicare claims, and we believe that such a requirement could only be implemented via a regulatory or statutory change. There may be privacy issues if we require a supplier to send bills to be paid by the Medicare carrier to another provider for review. In addition, we believe that CMS is not able to mandate the language to include in a contract that a SNF has with a supplier. This would be a private contract between two entities outside of our control. However, CMS has tasked one of its program safeguard contractors to conduct an analysis to ensure the effects of the prospective payment system for skilled nursing facility consolidated billing on improper billing to Medicare contractors. From this limited analysis, we may develop systematic approaches to address any improper payments, contingent upon available funding."

OIG Recommendation
Work with SNFs, suppliers, Medicare contractors, and other interested parties to identify "best practices" for communicating SNF resident payer information. Adoption of a "best practices" format for communicating payer information would enable SNFs and suppliers to utilize their resources more effectively.

CMS Response
We are in the process of writing a provider education article that will discuss SNF consolidated billing including ambulance, hospital outpatient, and globally billed physician services. The carriers and fiscal intermediaries (FIs) will be directed to post articles on their Web sites, using electronic mailing lists to notify providers that the information is available on their Web sites, and publish it in their next regularly scheduled bulletins.

OIG Recommendation
Direct FIs and carriers to continue to provide consolidated billing education and guidance to SNFs and suppliers, with an emphasis on ambulance, hospital outpatient, and globally billed physician services.

CMS Response
In order to implement this recommendation, we would incorporate such a requirement into our fiscal year 2004 Provider Communications Budget Performance Requirements.

OIG Recommendation
Incorporate language into consolidated billing regulations, program memoranda, and other CMS issued guidelines that clearly delineates the SNFs' responsibility to communicate information regarding a resident's payer status to their suppliers. The CMS should direct SNFs to establish controls to ensure that such information is communicated timely and accurately.

CMS Response
We believe that CMS does not have the authority to mandate the information SNFs must provide to the outside supplier and how it must be supplied. While OIG recommends that we "encourage" rather than "require" SNFs to share this information, the report should also explicitly acknowledge that we lack the authority to mandate this type of activity. At most, CMS can only act to help facilitate the voluntary performance of "best practices" in this area by those parties that elect to adopt them.

OIG Recommendation
Develop data anaylsis techniques to identify SNFs and suppliers associated with significant numbers of claims rejected or adjusted by the newly implemented prepayment and post payment edits. Any SNFs and suppliers that are repeatedly identified as non-

complaint with the consolidated billing requirements should be subject to appropriate corrective action.

CMS Response

The CMS will consider developing additional data analysis techniques to address this issue as we continually refine our prepayment and postpayment edits.