DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date DEC 29 1992

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Nationwide Review of Improper Medicare Payments for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-91-00511)

To William Toby, Jr.
Acting Administrator
Health Care Financing Administration

Attached is a final audit report on improper Medicare payments of approximately $38.5 million made by Medicare fiscal intermediaries (FI) to prospective payment system (PPS) hospitals for nonphysician outpatient services covering the period December 1987 through October 1990. We also identified about $12.9 million due to beneficiaries representing the coinsurance and deductible portions of the improper charges. Our figures are based on estimates derived from a statistical sample.

Under existing laws and regulations, PPS hospitals cannot bill separately for nonphysician outpatient services (such as radiology, other diagnostic tests, or laboratory services) provided on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge. The costs of such services are included in the PPS rates for each diagnosis related group (DRG). Through our analysis, we determined that improper payments were made because adequate computer edits and controls were not implemented at the hospitals' and in the FIs' claims processing systems. This has been a recurring problem since the inception of PPS in 1983. We have reported this condition to the Health Care Financing Administration (HCFA) in two prior reports entitled "Millions in Improper Payments to Hospitals for Nonphysician Services Under the Prospective Payment System - October 1, 1983 through January 31, 1986," issued on July 14, 1988 (A-01-86-62024) and "Improper Medicare Payments for Nonphysician Outpatient Services Under the Prospective Payment System - February 1986 through November 1987," issued on August 13, 1990 (A-01-90-00516).

We acknowledge that the Common Working File (CWF) was fully operational in January 1991 and, if properly implemented, should significantly curtail improper payments. As part of our oversight responsibilities, we will evaluate the controls related to this area under a separate audit using current data and

taking into consideration new Medicare regulations. The new Medicare regulations expand the DRG payment window to 3 days prior to the date of admission. Meanwhile, we are recommending that HCFA: (1) continue to notify hospitals that duplicate billings will be met with sanction penalties, (2) continue monitoring FI compliance with PPS laws and regulations preventing separate payment for nonphysician outpatient services through a more effective Intermediary System Testing Program process, (3) provide FIs with our computer tapes of potential improper payments for recovery, and (4) ensure that coinsurance and deductibles due to beneficiaries are refunded.

In response to our draft report, HCFA generally agreed with the recommendations and indicated it has already taken actions to improve upon its procedures. The HCFA, however, does not believe it is necessary at this time to issue a new transmittal on billing procedures to hospitals since the issuance of a prior transmittal was not shown to be ineffective. The HCFA would consider stronger action if our review covering the period under CWF shows the problem continues to exist.

In response to HCFA's concern, it should be noted that the FIs keep track of the number of instances an inpatient/outpatient claim suspends due to a prior payment of inpatient/outpatient claims. In addition, CWF generates a report showing the number of claims that are denied for payment because of previously paid claims. Our analysis of these reports along with our current computer match indicates that providers continue to improperly bill for services. As such, we believe reinforcement of correct billing procedures may be necessary.

Please advise us, within 60 days, on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NATIONWIDE REVIEW OF IMPROPER MEDICARE PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES UNDER THE PROSPECTIVE PAYMENT SYSTEM

DECEMBER 1992 A-01-91-00511

SUMMARY

Based on our completion of a series of computer matches of general-care hospital inpatient claims data and nonphysician outpatient services for the period December 1987 through October 1990 and a validation of the results, we estimate that about $38.5 million in improper payments for nonphysician outpatient services were made to hospitals. In addition, we estimate that Medicare beneficiaries were charged about $12.9 million for the 20 percent coinsurance and the deductible share relative to the improper payments.

Prior to our audit and as a result of actions taken on previous reports, an estimated $17.4 million in improper payments identified by the computer match had been corrected by the fiscal intermediaries (FI). Our computations are based on estimates derived from a statistical sample.

The objective of our audit was to determine whether and to what extent Medicare FIs enforce the laws and regulations preventing separate payments for nonphysician outpatient services on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge. Under the prospective payment system (PPS), for inpatient services rendered to Medicare beneficiaries, FIs reimburse hospitals a predetermined amount, depending on the illness and its classification under a diagnosis related group (DRG). The PPS law and related Medicare regulations provide that reimbursements for nonphysician hospital services (such as radiology, other diagnostic tests, and laboratory tests) furnished either on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge, be included in the predetermined amount.

Our analysis showed that improper payments were made because adequate computer edits and controls were not implemented at the hospitals' and in the FIs' claims processing systems. At the hospital level, inadvertent submission of claims, separate billing departments, lack of computer edits, personnel turnover, and misunderstanding of regulations were some of the reasons given for improper billing. At the FI level, computer edits (which were implemented to correct this problem) were not consistently followed and were overridden in order to pay a claim.

We examined actions taken by the Health Care Financing Administration (HCFA) to implement recommendations contained in our prior report covering the period February 1986 through November 1987, entitled "Improper Medicare Payments for Nonphysician Outpatient Services Under the Prospective Payment System" (A-01-90-00516). We had identified approximately $40 million in improper payments to hospitals under PPS for nonphysician outpatient services provided on the day before admission to the same hospital or during an inpatient stay, of which HCFA recouped approximately $31 million. In that report, we also recommended that HCFA, through

the FIs, instruct hospitals to refund coinsurance and deductibles related to the improper payments. While this recommendation was implemented, there is no evidence to indicate hospitals complied with these instructions. In order to curb improper payments, HCFA set forth additional instructions to hospitals emphasizing the importance of correct billing. Finally, the Common Working File (CWF) became fully operational in January 1991 and, if properly implemented, should significantly curtail improper payments. As part of our oversight responsibilities, we will evaluate the controls related to this area under a separate audit using current data and taking into consideration new Medicare regulations.

We recommend that HCFA continue to emphasize to hospitals that sanction penalties will be imposed unless adequate procedures to avoid improper billing are installed. We also recommend that HCFA continue monitoring FI compliance with PPS laws and regulations preventing separate payment for nonphysician outpatient services through a more effective Intermediary System Testing Program (ISTP) process. Finally, we recommend that HCFA instruct FIs to complete adjustments for improper payments made to hospitals and instruct hospitals to give beneficiaries refunds and/or credit for their deductible and coinsurance share of improper charges.

In response to our draft report, HCFA generally agrees with the recommendations and indicated it has already taken actions to improve upon its procedures. The HCFA, however, does not believe it is necessary at this time to issue a new transmittal on billing procedures to hospitals since the issuance of a transmittal in June 1990 was not shown to be ineffective. The HCFA would consider stronger action if our review covering the period under CWF shows the problem continues to exist.

In response to HCFA's concern, it should be noted that the FIs keep track of the number of instances an inpatient/outpatient claim suspends due to a prior payment of inpatient/outpatient claims. In addition, CWF generates a report showing the number of claims that are denied for payment because of previously paid claims. Our analysis of these reports, along with our current computer match, indicates that providers continue to improperly bill for services. As such, we believe reinforcement of correct billing procedures may be necessary.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Section 1886(d) of the Social Security Act, enacted by the Social Security Amendments of 1983, Public Law (P.L.) 98-21, on April 20, 1983, established PPS. For inpatient services furnished to Medicare beneficiaries, Medicare FIs reimburse hospitals a predetermined amount, depending on the illness and its classification under a DRG. As implemented by HCFA, separate payments for nonphysician outpatient services (such as radiology, other diagnostic tests, and laboratory tests) provided on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge are not permitted. Separate charges are not allowed because the Medicare laws and regulations require that the nonphysician outpatient services be considered as inpatient services. As such, the costs of the nonphysician outpatient services have been included in the inpatient operating costs in developing the predetermined PPS rates used to pay claims for each DRG billed.

Section 3610.3 of the Medicare Intermediary Manual states that,

> When an individual is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital before midnight of the next day, the outpatient hospital services furnished him are treated as inpatient services....Where the provision applies, services are included in the applicable DRG and not billed separately as outpatient services.

Furthermore, section 3670 of the Medicare Intermediary Manual requires FIs to develop a means of preventing duplicate payment of nonphysician outpatient services when the dates of service match those of an inpatient stay. We have observed that the FIs have taken some measures to prevent such payment within their own claims processing systems. They have also issued memorandums or bulletins instructing hospitals on the submission of claims for nonphysician outpatient services.

As of October 1990, 58 FIs were involved in reimbursing over 5,700 short term general-care PPS hospitals for nonphysician outpatient services to Medicare beneficiaries.

SCOPE

Our audit was made in accordance with generally accepted government auditing standards. The objective of our audit was to determine whether and to what extent FIs enforce the laws and regulations preventing separate payments for nonphysician outpatient services on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge. Our audit covered the period December 1987 through October 1990.

As part of our examination, we obtained an understanding of the internal control structure surrounding the processing of claims for nonphysician outpatient services. We concluded, however, that our consideration of the internal control structure could be conducted more efficiently by expanding substantive audit tests, thereby placing limited reliance on the hospitals' and FIs' internal control structure.

Accordingly, to accomplish our objective, we:

- reviewed applicable laws and regulations, Medicare and FI manuals, and HCFA's directives.

- reviewed recommendations made in our prior reports and corrective actions taken or contemplated by HCFA to determine if the recommendations were implemented.

- performed a computer match using HCFA's Medicare Part A paid claims file. We matched general-care hospital inpatient claims data to nonphysician outpatient claims data for the audit period and identified 574,743 potential improper payments for nonphysician outpatient services valued at $85,453,124.

- employed a multistage statistical sampling approach. Our primary sampling unit consisted of 8 FIs from a population of 58 FIs with potential improper payments for nonphysician outpatient services. The secondary sampling unit consisted of 50 claims at each of these FIs (a total of 400 claims valued at $52,942).

- requested for each of the 400 claims randomly selected in our sample, that the FIs, along with their hospitals, submit documentation (billing histories, hospital bills, medical records, etc.) to us for review. We also requested that both the FI and hospitals provide us with information as to why the claims were submitted and paid and to what extent improvements have been made to prevent improper payments from recurring.

- o used a variable appraisal program to estimate the dollar impact of improper payments in the total population, as well as the estimated dollar impact of unnecessary charges to beneficiaries for coinsurances and deductibles.

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 towards assessing the completeness of the file from which the data was obtained.

Our audit included all PPS hospitals nationwide except those hospitals in Maryland and U.S. Territories which did not participate in PPS through the period covered by our audit. Also, claims with dates of service prior to January 1, 1989 and October 1, 1987 from hospitals in New Jersey and Puerto Rico, respectively, were not included in our audit because the hospitals did not participate in PPS prior to those periods.

For those items tested, we found no instances of noncompliance except for the matters discussed in the Findings and Recommendations section of this report. Regarding the items not tested, nothing came to our attention to cause us to believe that untested items would produce different results. For example, the outpatient claim could include services 5 days before as well as during the inpatient stay. The payment for services during the inpatient stay would be improper.

Our field work was performed from June 1991 to January 1992 at the HCFA central office in Baltimore, Maryland; selected FIs in Region I; and at the Office of Audit Services (OAS) in Boston, Massachusetts.

The draft report was issued to HCFA on May 7, 1992. The HCFA's written comments, dated September 16, 1992, are appended to this report (see Appendix III) and addressed on page 10.

FINDINGS AND RECOMMENDATIONS

Since the inception of PPS in 1983, improper billings and subsequent payments were made despite regulations which prohibit separate billing and payment for nonphysician outpatient services furnished to Medicare beneficiaries either on the day before admission to the same hospital or during an inpatient stay, excluding the day of discharge. This problem was brought to HCFA's attention in two separate reports covering the periods October 1983 through January 1986 and February 1986 through November 1987 in which we identified $27 million and $40 million, respectively, in improper payments.

For the period December 1987 through October 1990, we completed a series of computer matches using HCFA's Medicare Part A paid claims file containing general-care hospital inpatient claims data and nonphysician outpatient claims data. We identified 574,743 potential improper payments for nonphysician outpatient services valued at about $85.5 million (see Appendix II). These claims were submitted by over 5,700 hospitals to 58 FIs. Based on a statistical projection, we estimate that about $38.5 million in improper payments for nonphysician outpatient services were made to hospitals for the audit period. We identified an additional $17.4 million in improper payments which have been corrected by the FIs[1]. We believe that these corrections result from an increased awareness generated from our prior reports. In addition to the improper payments to hospitals, we estimate that Medicare beneficiaries were charged approximately $12.9 million for the 20 percent coinsurance and the deductible share relative to the improper payments.

VALIDATION AND IDENTIFICATION OF IMPROPER PAYMENTS TO HOSPITALS

To validate our data and to estimate potential improper payments, we employed a multistage statistical sampling approach. In this regard, a primary unit was an FI and a secondary unit was a claim for nonphysician outpatient services. We selected 8 FIs from a population of 58 FIs, and 50 claims were selected from the population of claims at each of the 8 FIs for a total of 400 claims (see Appendix I for details of the methodology for statistical sample selection).

We provided each FI with its sample claims. For each of the 400 claims, we requested that the FIs with their hospitals, submit documentation (billing histories,

---

[1] The $29.6 million difference between the value of the 574,743 potential improper payments and what is estimated as improper payments and payments already corrected by the FIs is related to proper payments described on page 5.

hospital bills, medical records, etc.) in order for us to determine the appropriateness of the payment.

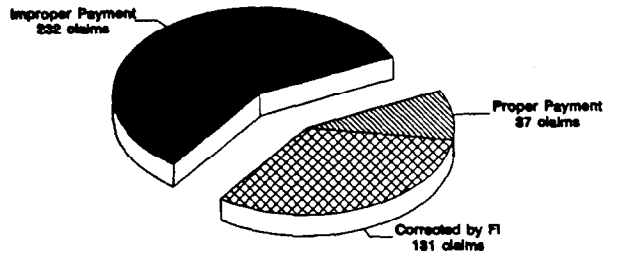

***Figure 1** - Results of the Sample*

Figure 1 shows the breakdown of our analysis of the 400 claims. We also requested that both the FI and hospitals provide us with information as to why the claims were submitted and paid and what improvements have been made to prevent this situation from recurring. Proper payments consisted of services rendered on the days when the beneficiary had exhausted available Medicare Part A benefits or during a leave of absence. Section 1812 of the Social Security Act sets forth limitations on the amount of inpatient benefits. Once a beneficiary has exhausted these benefits, payment may be made to hospitals under Part B. Furthermore, Medicare Provider Manual section 2205.4 provides that days of a leave of absence are not treated as inpatient days. In our review of the 400 claims and supporting medical records, it was determined that in some cases the dates of service did not agree with the medical records. The medical records indicated the correct dates of service. In these cases, the claims were proper.

As a result of reviewing the 400 claims with a dollar value of $52,942 and extrapolating the result of the statistical sample over the population using standard statistical methods, we found the following:

- A total of 232 claims valued at $33,026 were improperly paid. The estimated dollar impact of improper payments in the universe is $38,511,916 with a precision of this estimate at the 90 percent confidence level of ± 28.86 percent.

- A total of 131 claims valued at $12,798 were corrected by the FIs, primarily on the basis of recommendations contained in our prior reports. The estimated dollar amount already recovered from the universe by the FIs is $17,433,215 with a precision of this estimate at the 90 percent confidence level of ± 46.31 percent.

- A total of 171 of the 232 claims involved unnecessary payments of $11,623 by beneficiaries for their coinsurance of 20 percent for the improperly paid claims[2]. The estimated dollar impact on the beneficiaries is $12,944,396 with a precision of this estimate at the 90 percent confidence level of ± 31.67 percent.

WEAKNESSES AND IMPROVEMENTS IN CLAIMS PROCESSING

Based on the responses from the eight FIs and the hospitals involved in the sample and discussions with FIs in Region I, we believe that the improper payments were the result of inadequate controls at the hospital and at the FI levels. At the hospital level, the following were reasons cited for improper billing:

- inadvertent submission of claims,
- separate billing departments,
- lack of computer edits,
- personnel turnover, and
- misunderstanding of regulations.

At the FI level, computer edits, which were implemented to correct the deficiencies in the claims processing systems, were not consistently adhered to and were overridden to pay a claim. Coupling this shortcoming of the computer edits with the weaknesses in the billing systems at the hospitals demonstrates that adequate improvements were not implemented, as recommended in our prior reports.

Hospital officials indicated that improvements have been recently or are in the process of being implemented. The most significant improvement mentioned was new computer systems integrating inpatient and outpatient billing. Other improvements include claims being held for a time before submission and manual review of outpatient billings for possible admissions. At the FI level, continual upgrading of computer edits and the implementation of CWF were indicated as improvements.

---

[2]Sixty-one of the 232 claims did not have an associated beneficiary coinsurance and/or deductible.

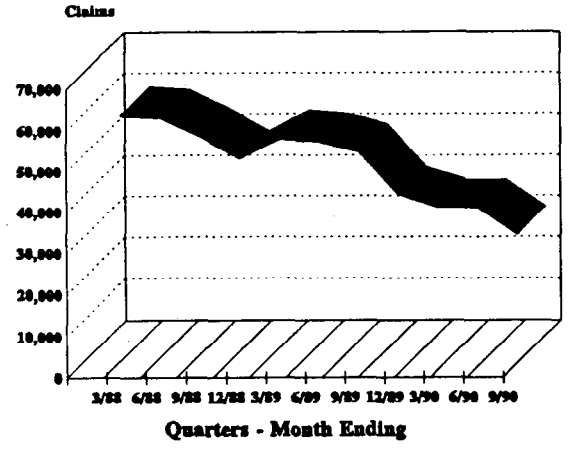

Figure 2 - Quarterly Aging of the Number of Potential Improper Payments for Nonphysician Outpatient Services

As shown by Figure 2, these improvements have decreased the number of potentially improper payments. Our analysis showed, however, that the decrease was, in part, attributable to improved FI computer edits rather than CWF. On June 22, 1987, implementation of CWF as a prepayment edit screen began. The HCFA indicated that early in the implementation of CWF, CWF did not alert FIs to potential improper payments nor reject claims which would lead to an improper payment. In 1990, CWF was changed to generate alerts to FIs apprising them of potential improper payments. If the alert was not addressed, claims for both nonphysician outpatient services and inpatient services were allowed to be paid. We acknowledge that CWF was fully operational in January 1991 and, if properly implemented, should curtail these improper payments.

FOLLOW-UP ON PRIOR RECOMMENDATIONS

We have reviewed the payments of nonphysician outpatient services since the inception of PPS in 1983 (A-01-86-62024 and A-01-90-00516). During our current audit, we evaluated actions taken and contemplated by HCFA on recommendations in our last report. Listed below are the five recommendations to HCFA from the latter report and corrective actions taken.

Recommendation 1

- Continue monitoring FI compliance with the PPS laws and regulations preventing separate payment for nonphysician outpatient services. A more effective ISTP process, supplemented by regional office oversight, would be appropriate for this purpose.

In its response, dated October 9, 1990 to our final report, HCFA indicated that it would include three additional test claims in the Fiscal Year (FY) 1990 ISTP. For the FY 1990 and FY 1991 ISTP, HCFA included four test claims in each year to test overlapping or duplicate inpatient and nonphysician outpatient services. The claims tested for nonphysician outpatient services provided on the day before admission

to the same PPS hospital (two claims), the day of discharge, and a range of dates overlapping the inpatient stay. Errors were found at three FIs, and the appropriate regional offices followed up to ensure these errors were corrected. We believe that monitoring through the ISTP should be continued with more comprehensive test claims covering the myriad of claims which can be submitted by hospitals.

Recommendation 2

- Put providers on notice once again that adequate billing procedures must be established to prevent duplicate billings or sanction penalties will be imposed.

The HCFA issued transmittal number 592 in June 1990 which addressed this recommendation.

Recommendation 3

- Provide FIs with our computer tapes of improper payments and advise them to make appropriate adjustments.

We provided HCFA with a computer tape containing improper payments. These tapes were provided to the FIs in January 1990. The HCFA reported that about $31 million was recouped.

Recommendation 4

- Take action necessary through the FIs to obtain assurances that beneficiaries receive refunds and/or credits, where due, for the coinsurance share and deductible portion of improper payments.

The HCFA instructed the FIs to inform the hospitals that any coinsurance and deductible associated with the $31 million in duplicate payments should be refunded to the beneficiaries. Based on discussions with FIs in Region I, the FIs did inform the hospitals to refund the coinsurance and deductible, however, there was no follow-up to ensure this was done. Accordingly, the extent of compliance with the HCFA directive is not known on a nationwide basis.

Recommendation 5

- Report the material internal control weakness as "uncorrected" in the FY 1990 Federal Managers' Financial Integrity Act (FMFIA) report to the President and the Congress.

This issue has been reported as a material weakness in the FMFIA reports to the President and the Congress since 1988. The HCFA again reported this material control weakness in the December 1990 FMFIA report. The target correction date was 1991. Corrective actions included changes to CWF, revised ISTP, and transmittal number 592 noted above. The report also noted a validation of the CWF computer edits could be conducted by the Office of Inspector General (OIG). We are beginning a separate review which will test these computer edits.

CONCLUSIONS

For the period December 1987 through October 1990, significant potential improper payments were continually made by FIs nationwide for nonphysician outpatient services which should have been billed as part of a provider's inpatient claim. In addition, Medicare beneficiaries were burdened unnecessarily in paying coinsurance and deductibles for claims which should not have been processed for payment. We noted that the weaknesses persisted in the claims processing systems of both the hospitals and FIs to precipitate payment of these services. We noted improvements which fell short of correcting this problem. We should note that during our field work, we encountered many concerns from hospitals and FIs relative to the age of the claims and the cost of a recoupment process. We acknowledge that the cost of a recoupment process, both in time and resources, can be relatively high, however, the estimated $38.5 million in potential improper payments far outweigh those costs.

RECOMMENDATIONS

We recommend that HCFA:

1. continue to emphasize to hospitals that they will be subject to sanction penalties unless they install adequate procedures to avoid improper billing.

2. continue monitoring FI compliance with the PPS law and regulations preventing separate payment for nonphysician hospital services. A more effective ISTP process, supplemented by regional office oversight, would be appropriate for this purpose.

3. provide FIs with our computer tapes of improper payments and advise them to make appropriate adjustments.

4. require FIs to instruct providers to refund the coinsurance share and deductible portion of improper payments to beneficiaries and to take necessary action to ensure that beneficiaries receive refunds.

HCFA'S COMMENTS

In response to our draft report, HCFA generally agrees with the recommendations and indicated it has already taken actions to improve upon its procedures. The HCFA, however, does not believe it is necessary at this time to issue a new transmittal on billing procedures to hospitals since the issuance of transmittal number 592, in June 1990, was not shown to be ineffective. The HCFA would consider stronger action if our review covering the period under CWF shows the problem continues to exist. The HCFA's corrective actions regarding the remaining recommendations are as follows:

- The HCFA indicated it has included test bills in the ISTP that will test eight different situations relating to this issue. It has also taken a number of steps to ensure a more thorough and consistent review of the ISTP results by the regional offices.

- The HCFA has received the OIG computer tapes containing the potential improper payments and has transmitted these tapes to the respective FIs.

- The HCFA has directed the FIs to instruct providers to refund the coinsurance and deductible portions of any actual overpayments. The FIs will be expected to monitor provider compliance with this instruction.

OIG RESPONSE

In response to HCFA's concern, it should be noted that the FIs keep track of the number of instances an inpatient/outpatient claim suspends due to a prior payment of inpatient/outpatient claims. In addition, CWF generates a report showing the number of claims that are denied for payment because of previously paid claims. Our analysis of these reports along with our current computer match indicates that providers continue to improperly bill for services. As such, we believe reinforcement of correct billing procedures may be necessary.

With respect to HCFA's technical comments, we revised our final report to address these concerns.

APPENDICES

METHODOLOGY OF STATISTICAL SAMPLE SELECTION

To select a sample for validating our data and estimating the potential improper payments for nonphysician outpatient services, we employed a multistage sample based on probability-proportional-to-size weighted by dollar value at each FI. The sample was drawn from 58 FIs which processed 574,743 claims for nonphysician outpatient services (valued at $85.4 million) (see Appendix II). Thus, the primary sampling units consisted of 8 FIs and our secondary units consisted of 50 claims at each FI (a total of 400 claims).

To select our primary sample units, the following steps were conducted:

- for each FI, the number of claims and the value of these claims were determined;
- the 58 primary units were divided among 8 random groups; and
- one FI was then selected from each of the 8 groups with chance of selection proportional to their respective dollar value within that group.

The following FIs were selected:

	Total Paid Amount	Claim Count
BLUE CROSS OF FLORIDA	$ 5,741,126	27,933
BLUE CROSS OF IOWA	1,156,238	9,017
BLUE CROSS OF MASSACHUSETTS	2,264,895	12,026
BLUE CROSS OF NEW JERSEY	1,225,915	8,890
EMPIRE BLUE CROSS	16,361,985	88,918
BLUE CROSS OF TENNESSEE	1,880,368	18,209
BLUE CROSS OF WASHINGTON ALASKA	1,121,069	7,694
MUTUAL OF OMAHA	2,211,592	15,393

The selection of secondary units was by a simple random sample of claims for nonphysician outpatient services. Fifty claims were selected from the population of claims at each of the eight FIs.

All random selections were made using the OAS' Statistical Software dated May 1990.

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER PAYMENTS TO PPS HOSPITALS FOR NONPHYSICIAN OUTPATIENT SERVICES DECEMBER 1987 THROUGH OCTOBER 1990

INTERMEDIARY	PAID AMOUNT	CLAIM COUNT
00010-BC OF ALABAMA	$ 1,143,669	12,130
00020-BC OF ARKANSAS	748,687	7,483
00030-BC OF ARIZONA	839,847	3,377
00040-BC OF CALIFORNIA	3,322,936	11,664
00050-COLORADO HOSPITAL SERVICE	479,728	3,220
00060-BC OF CONNECTICUT	397,503	1,936
00070-BC OF DELAWARE	287,966	2,305
00080-GROUP HOSPITALIZATION IND. DC	100,219	443
00090-BC OF FLORIDA	5,741,126	27,933
00101-BC OF GEORGIA	1,728,995	15,979
00121-HEALTH CARE SERVICE CORP ILLINOIS	1,927,846	10,758
00130-MUTUAL HOSPITAL INSURANCE INC INDIANA	2,167,529	18,254
00140-BC OF IOWA	1,156,238	9,017
00141-BC OF WESTERN IOWA & SOUTH DAKOTA	239,251	2,245
00150-BC OF KANSAS	622,858	4,864
00160-BC OF KENTUCKY	445,283	3,756
00170-BC OF LOUISIANA	1,221,032	10,341
00180-ASSOCIATED HOSPITAL SERVICE OF MAINE	523,890	4,414
00190-BC OF MARYLAND	523,923	2,069
00200-BC OF MASSACHUSETTS	2,264,895	12,026
00210-BC OF MICHIGAN	3,003,032	16,750
00220-BC OF MINNESOTA	533,616	5,436
00230-BC OF MISSISSIPPI	291,350	3,598
00231-BC OF LOUISIANA	10,156	65
00241-BC OF HOSPITAL SERVICE OF MISSOURI	2,802,085	17,622
00250-BC OF MONTANA	236,743	2,163
00260-BC OF NEBRASKA	211,678	2,292
00270-NEW HAMPSHIRE/VERMONT HOSPITAL SERVICE	504,231	3,462
00280-HOSPITAL SERVICE PLAN OF NEW JERSEY	1,225,915	8,890
00290-NEW MEXICO BC	1,824,615	6,881
00308-EMPIRE BC	16,361,985	88,918
00310-NORTH CAROLINA BC	2,705,078	22,306
00320-BC OF NORTH DAKOTA	91,120	724
00332-HOSPITAL CARE CORP OHIO	4,675,219	35,181
00340-BC OF OKLAHOMA	541,317	4,765

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER PAYMENTS TO PPS HOSPITALS FOR NONPHYSICIAN OUTPATIENT SERVICES DECEMBER 1987 THROUGH OCTOBER 1990

INTERMEDIARY	PAID AMOUNT	CLAIM COUNT
00350-NORTHWEST HOSPITAL SERVICE OREGON	$ 678,662	4,302
00351-BC OF IDAHO	149,862	1,260
00362-BC OF GREATER PHILADELPHIA	1,383,193	9,589
00363-BC OF WESTERN PENNSYLVANIA	3,580,693	38,624
00370-BC OF RHODE ISLAND	512,695	2,787
00380-BC OF SOUTH CAROLINA	2,270,716	11,533
00390-BC OF TENNESSEE	1,880,368	18,209
00400-GROUP HEALTH SERVICE INC TEXAS	1,136,818	6,453
00410-BC OF UTAH	213,789	969
00423-BC OF VIRGINIA	1,446,251	9,929
00430-BC OF WASHINGTON ALASKA	1,121,069	7,694
00441-BC HOSPITAL SERVICE INC WEST VIRGINIA	436,855	4,574
00450-ASSOCIATED HOSPITAL SERVICE IN WISCONSIN	1,872,063	16,814
00460-WYOMING HOSPITAL SERVICE	110,532	938
00468-COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO	147,665	3,589
17120-HAWAII GUAM MEDICAL SERVICE ASSOCIATION	455,686	1,752
50333-TIC NEW YORK	343,860	2,485
51051-AETNA CALIFORNIA	1,965,706	11,931
51070-AETNA CONNECTICUT	1,022,528	7,542
51100-AETNA FLORIDA	71,145	680
51140-AETNA ILLINOIS	262,106	2,861
51390-AETNA PENNSYLVANIA	1,277,709	11,568
52280-MUTUAL OF OMAHA	2,211,592	15,393
TOTAL	$85,453,124	574,743

SEP 16 1992

Memorandum

Date

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Report: "Nationwide Review of Improper Medicare Payments for Nonphysician Outpatient Services Under the Prospective Payment System, (PPS)", A-01-91-00511

To Byran B. Mitchell
Principal Deputy Inspector General

We have reviewed the subject draft report in which OIG sought to determine the extent to which Medicare fiscal intermediaries (FI) enforce the laws and regulations preventing separate payments for nonphysician outpatient services on the day before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge. Under PPS, hospitals are not allowed to accept such payments.

This report addresses the period from December 1987 to October 1990. During that time, OIG estimates that improper program payments in the amount of $38.5 million were made for nonphysician outpatient services. Additionally, OIG asserts that Medicare beneficiaries were unnecessarily burdened by paying coinsurance amounts and deductibles on claims for these services. Though OIG acknowledges corrective actions were taken by the Health Care Financing Administration (HCFA), both independently and in response to earlier OIG audits, OIG states that improper payments continued to be made because weaknesses in Medicare contractors' claims processing systems persisted.

While OIG notes that the recoupment process is costly, it believes recoveries for this period will outweigh such costs. Consequently, OIG recommends that HCFA:

(1) continue to emphasize to hospitals that they will be subject to sanction penalties unless they install adequate procedures to avoid improper billing;

(2) continue to monitor FI compliance with the PPS law and regulations preventing separate payment for nonphysician hospital services through a more effective Intermediary System Testing Program process supplemented by regional office oversight;

(3) provide FIs with OIG's computer tapes of improper payments cited in this report, and advise them to make appropriate adjustments; and

(4) require FIs to instruct providers to refund the coinsurance share and deductible portion of improper payments to beneficiaries and to take necessary action to ensure that beneficiaries receive refunds.

HCFA generally agrees with these recommendations and has already taken actions in accordance with these goals. However, we do not believe it is necessary to issue a new transmittal on billing procedures to meet the requirements of OIG's first recommendation since issuance of a transmittal in June 1990 fulfilled this recommendation. This audit does not establish that the earlier transmittal was ineffective, mostly because the audit's scope is limited to the period December 1987 through October 1990.

Our specific comments on the report's recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft report. Please advise us whether you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA)
Office of Inspector General (OIG) Draft Report: "Nationwide Review of Improper Medicare Payments for Nonphysician Outpatient Services Under the Prospective Payment System (PPS)," A-01-91-00511

Recommendation 1

That HCFA continue to emphasize to hospitals that they will be subject to sanction penalties unless they install adequate procedures to avoid improper billing.

HCFA Response

While we agree that hospital compliance with HCFA billing instructions should continue to be monitored, we do not believe an additional transmittal on this subject is necessary. We issued a Hospital Manual transmittal in June 1990 that was effective within the month. We believe the transmittal fulfilled this recommendation. Evidence we have evaluated since June 1990 suggests that improper billing has continued to diminish.

We would consider stronger action if OIG's follow-up review on the status of hospital billing shows that a problem continues to exist. However, this audit does not establish that the June 1990 is transmittal was ineffective. Since the scope of the audit is limited to the period December 1987 through October 1990, only the first 4 months after the transmittal became effective are considered. Also, the report itself discusses a number of steps hospitals have taken to improve their billing practices and shows that the number of potential improper payments for nonphysician outpatient services has declined dramatically from 1988 through September 1990.

Recommendation 2

That HCFA continue to monitor fiscal intermediary (FI) compliance with the PPS law and regulations preventing separate payment for nonphysician hospital services through a more effective Intermediary System Testing Program (ISTP) process supplemented by regional office (RO) oversight.

HCFA Response

We agree with this recommendation. We believe we have made substantial progress toward this goal with respect to the 1992 Intermediary System Testing Program (ISTP).

This year, we have included test bills in the ISTP that will test eight different situations relating to this issue. We have also taken a number of steps to ensure a more thorough and consistent review of the ISTP results by the ROs. We have provided a variety of instructional materials to the ROs, including a review guide and detailed answer sheets. We have also added a more formal protocol for verifying the adequacy of corrections to the current ISTP process.

The final results of the 1992 ISTP will be available late this year. We are willing to provide additional documentation on our efforts in this area should OIG desire.

Recommendation 3

That HCFA provide FIs with OIG's computer tapes of improper payments cited in this report and advise them to make appropriate adjustments.

HCFA Response

We agree to pursue the recovery of the estimated $38.5 million in improper payments identified in this report. We have received the computer tapes from OIG and will transmit them to the FIs for action. We will keep OIG apprised of our progress on this recovery effort.

We note that the cost of this recovery project will substantially exceed the funds expended for similar projects in the past because the FI Internal Control Number (ICN) was deleted from claims information during the period in question. The ICN is used by intermediaries to identify the cases involved. As a consequence, intermediaries will have to expend more resources to identify and work the cases cited by OIG.

This issue will also affect other OIG-initiated recoveries involving the same time period. Fortunately, the ICN data are now being retained.

Recommendation 4

That HCFA require FIs to instruct providers to refund the coinsurance share and deductible portion of improper payments to beneficiaries and take necessary action to ensure that beneficiaries receive refunds.

HCFA Response

We agree. We will direct the FIs to instruct providers to refund the coinsurance and deductible portions of any actual improper payments identified during the recovery project to beneficiaries. FIs will be expected to monitor provider compliance with this instruction.

Technical Comments

- The first paragraph on the first page of this report cites provisions of Public Law 98-21 as prohibiting separate payments for nonphysician outpatient services provided on the day before inpatient admission. However, no such provision actually exists in the statute.

  HCFA first imposed this requirement administratively. Subsequently, section 4003 of the Omnibus Budget Reconciliation Act of 1990 amended section 1886(a)(4) of the Social Security Act (the Act) to require the bundling of services furnished by a hospital to a patient "during the 3 days immediately preceding the date of the patient's admission if such services are diagnostic services . . . or are other services related to the admissions . . . ."

  Therefore, we suggest this paragraph be amended to read as follows:

  > As implemented by HCFA, separate payments for nonphysician outpatient services provided on the day before admission were not permitted.

- On page 5, the second paragraph states in part that Medicare regulations at 42 CFR 409.61 set forth limitations on the amount of inpatient benefits. We suggest instead referring to the statute on which that regulation is based as section 1812 of the Act (42 U.S.C. 1395d).

- On page 7, OIG is correct in stating that the Common Working File (CWF) did not initially contain edits to detect billings for outpatient services which were provided during an inpatient stay. We implemented CWF edits which returned such claims to the FIs in January 1991, after the close of the period reviewed by OIG in the present report. The upcoming OIG report should serve as a validation of the effectiveness of the new edits.

- As mentioned on page 9 of this report, duplicate payments under PPS were declared a material weakness (MW). However, OIG does not acknowledge that this MW was first declared in fiscal year (FY) 1988, not FY 1990, and has been tracked under the Federal Managers' Financial Integrity Act (FMFIA) program since the earlier date.

HCFA declared the PPS MW corrected in the FY 1991 Annual FMFIA report. Since the Department requires that a corrective action review (CAR) be conducted within 1 year of the correction of an MW, we asked OIG to conduct a CAR to confirm that this MW was in fact corrected. We assume that the forthcoming OIG study will serve as the requested CAR.

- At a minimum, the word "potential" should be inserted into the title for Appendix II (both pages) before the words "improper payments." Even this change will not adequately qualify the listing, since we note that about $47 million of the $85.5 million in "potential" overpayments identified by OIG will actually turn out to be either appropriate payments or overpayments that have already been corrected by providers and hospitals.