MAY 23 1996

Memorandum

Date

From Michael Mangano for June Gibbs Brown
Inspector General

Subject
Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System (A-01-95-00508)

To
Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, *Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System*. The objective of our review is to determine if the necessary controls are in place to preclude payment to hospitals for nonphysician outpatient services rendered during the diagnosis-related group (DRG) payment window.

Under current Medicare regulations, separate payment for nonphysician outpatient services rendered within the DRG payment window are not permitted. However, we identified over $27 million in potential improper billings and subsequent payments for nonphysician outpatient services rendered within the DRG payment window for the period January 1992 through December 1994.

We should point out that this ongoing review is the fifth review on this subject. As a result of the first three reviews, covering the period October 1983 through October 1990, over $100 million in improper payments were recovered by the Health Care Financing Administration (HCFA). We are currently involved in a joint project with the Department of Justice (DOJ) to recover overpayments and assess appropriate penalties and interest on improper payments made from November 1990 to December 1994.

Our analysis indicates that the improper billings and subsequent payments were the result of insufficient controls at the hospitals and in the claims processing systems at the fiscal intermediaries and the Common Working File (CWF). Specifically, hospitals cited these reasons for improper billings: (1) ineffective data exchange between inpatient and outpatient departments; (2) outpatient hospital was unaware that the patient was an inpatient at another hospital; and (3) no hospital system edit to identify admission-related nondiagnostic services (principal diagnosis codes are the same) rendered within the 72-hour payment window. With respect to the claims processing systems, our analysis indicates that the necessary edits were not sufficient, "turned-off," or nonexistent during the January 1992 through December 1994 time period.

We acknowledge HCFA's past efforts to educate hospitals on the proper billing procedures for nonphysician outpatient services. It is apparent from this review, however, that this education process has not worked. As indicated, our office has initiated a joint project with the DOJ to recover any overpayments. Through this joint project, the overpayments will be recovered, penalties and interest will be assessed, coinsurance will be refunded, and measures will be taken to ensure hospitals have the necessary systems in place to curtail this situation.

Notwithstanding the joint recovery project underway for the overpayment and related coinsurance and deductible, we believe HCFA should:

❶ review CWF to ensure all edits are active and, if required, develop edits to address the legislative requirements set forth by Medicare laws; and

❷ incorporate into the design of the Medicare Transaction System (MTS) edits which address all legislative requirements which prohibit separate payment for nonphysician outpatient services rendered within the DRG payment window.

In response to our draft report, HCFA concurred with both recommendations. The HCFA indicated that it conducted a review of the CWF and has all appropriate edits turned on and working properly. Furthermore, a series of edits was recently implemented and updated. The HCFA also indicated that CWF will be in complete compliance with the Omnibus Budget Reconciliation Act of 1990 (OBRA '90) legislation by July of 1996. With respect to the MTS edits, HCFA indicated that the MTS workgroup will take our draft report under advisement and design the system accordingly.

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) 786-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-01-95-00508 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

IMPROPER MEDICARE PAYMENTS TO HOSPITALS FOR NONPHYSICIAN OUTPATIENT SERVICES UNDER THE PROSPECTIVE PAYMENT SYSTEM

JUNE GIBBS BROWN
Inspector General

MAY 1996
A-01-95-00508

EXECUTIVE SUMMARY

The objective of our review is to determine if the necessary controls are in place to preclude payment to hospitals for nonphysician outpatient services rendered during the diagnosis-related group (DRG) payment window.[1] Under current Medicare regulations, separate payment for nonphysician outpatient services rendered within the DRG payment window are not permitted. However, we identified a potential of over $27 million in improper billings and subsequent payments for nonphysician services rendered within the DRG payment window for the period January 1992 through December 1994. Our analysis at selected hospitals and fiscal intermediaries (FI) indicates that, for the period under review, improper billings and payments were made due to insufficient or nonexistent controls at both the hospital and FI level.

We should point out that this ongoing review is the fifth review on this subject. As a result of the first three reviews, covering the period October 1983 through October 1990, over $100 million in improper payments were recovered by the Health Care Financing Administration (HCFA). We are currently involved in a joint project with the Department of Justice to recover overpayments and assess appropriate penalties and interest on improper payments made from November 1990 to December 1994.

BACKGROUND

Under the prospective payment system (PPS) , Medicare FIs reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a DRG. It has been HCFA's longstanding policy to treat any nonphysician outpatient services rendered the day before admission, the day of admission, or during the inpatient stay as inpatient services. To curb further unbundling of services which has occurred since the introduction of PPS, the DRG payment window was expanded to include services rendered up to 72 hours prior to admission. As such, separate payments are not allowed for:

- any nonphysician outpatient services rendered on the day of admission or during an inpatient stay;
- diagnostic services rendered up to 72 hours before the day of admission; or
- admission-related nondiagnostic services rendered up to 72 hours before the day of admission.

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[1] The DRG payment window is defined as 72 hours prior to the day of admission to but not including the day of discharge.

RESULTS

We conducted a series of computer matches of general-care hospital inpatient claims data to nonphysician outpatient claims data for the 3-year period January 1992 through December 1994 and identified over 197,000 potential improper claims, valued at over $27 million, submitted by over 4,900 hospitals nationwide. Our analysis indicates that the improper billings and subsequent payments were the result of insufficient controls at the hospitals and in the claims processing systems at the FIs and the Common Working File (CWF). Hospitals have cited the following reasons for improper billings:

- ineffective data exchange between inpatient and outpatient departments;
- outpatient hospital was unaware that the patient was an inpatient at another hospital; and
- no hospital system edit to identify admission related nondiagnostic services (principal diagnosis codes are the same) rendered within the 72-hour payment window.

With respect to the claims processing systems, our analysis indicates that the necessary edits were not sufficient, "turned-off," or nonexistent during the January 1992 through December 1994 time period.

We acknowledge HCFA's past efforts to educate hospitals on the proper billing procedures for nonphysician outpatient services. It is apparent from this review, however, that this education process has not worked. As indicated, the Office of Inspector General (OIG) has initiated a joint project with the Department of Justice to recover any overpayments. Through this joint project, the overpayments will be recovered, penalties and interest will be assessed, coinsurance will be refunded, and measures will be taken to ensure hospitals have the necessary systems in place to curtail this situation.

RECOMMENDATIONS

Notwithstanding the joint recovery project underway for the overpayment and related coinsurance and deductible, we believe HCFA should:

1. review CWF to ensure all edits are active and, if required, develop edits to address the legislative requirements set forth by the Omnibus Budget Reconciliation Act of 1990 (OBRA '90); and

- incorporate into the design of the Medicare Transaction System (MTS) edits which address all legislative requirements set forth by OBRA '90 which prohibit separate payment for nonphysician outpatient services rendered within the DRG payment window.

In response to our draft report, HCFA concurred with both recommendations. The HCFA indicated that it conducted a review of the CWF and has all appropriate edits turned on and working properly. Furthermore, a series of edits were recently implemented and updated. The HCFA also indicated that CWF will be in complete compliance with OBRA '90 legislation by July of 1996. With respect to the MTS edits, HCFA indicated that the MTS workgroup will take our draft report under advisement and design the system accordingly.

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INTRODUCTION

BACKGROUND

Section 1886(d) of the Social Security Act, enacted by the Social Security Amendments of 1983, Public Law (P.L.) 98-21, established the prospective payment system (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 the 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. This was referred to as the 24-hour rule. Separate charges were not allowed because HCFA's longstanding policy is to consider these nonphysician outpatient services 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.

Effective January 1, 1991, OBRA '90, Public Law 101-508, section 4003, extended the DRG payment window to preclude payment of nonphysician outpatient services up to 72 hours immediately preceding the day of admission. This amendment applies to:

- any nonphysician outpatient services rendered on the day before, the day of, or during an inpatient stay at a PPS hospital regardless of whether the services are admission related[2] (effective for services furnished before October 1, 1991); or

- diagnostic nonphysician outpatient services rendered up to 72 hours before the day of admission (effective for services furnished after January 1, 1991); or

- nondiagnostic nonphysician outpatient services rendered up to 72 hours before the day of admission and are admission related (effective for services furnished after October 1, 1991). **This last provision of OBRA '90 was not implemented by HCFA until July 1992.**

Section 3670 of the Medicare Intermediary Manual (MIM) requires FIs to develop a system to prevent duplicate payment of nonphysician outpatient services. If a duplicate payment has been made, FIs should initiate appropriate recovery action and instruct the provider to refund to the beneficiary any coinsurance and deductible collected. As a supplement to the FIs' processing systems, the CWF is a prepayment validation system designed to avoid improper payment through a comparison of Part A and Part B claims data. These prepayment edits are designed to eliminate costly adjustment processing and overpayment recovery activities. In January 1991, CWF edits were revised to address the provisions of OBRA '90. The HCFA has currently under development the Medicare Transaction System (MTS) which will be a single, national, standard

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[2] Services are considered admission related if they are furnished in connection with the principal diagnosis that necessitates the inpatient admission.

and integrated claims processing system for both Medicare Part A and Part B claims. The MTS system will replace both the FIs' and CWF claims processing systems.

SCOPE

Our audit was made in accordance with generally accepted government auditing standards. The objective of our review is to determine if the necessary controls are in place to preclude payment to hospitals for nonphysician outpatient services rendered during the DRG payment window. Our audit covered the period Calendar Years (CY) 1992 through 1994.

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;
- performed several computer applications using HCFA's National Claims History file. We matched general-care hospital inpatient claims data to nonphysician outpatient claims data for the audit period and identified 197,879 claims for nonphysician outpatient services valued at $35,162,593;
- reviewed a judgmental sample of claims (271 valued at $87,423) submitted by 5 hospitals in Massachusetts and Connecticut (these claims were processed by 3 FIs) to validate the results of our computer match for CYs 1992 and 1993;
- to validate the computer match for CY 1994, claims data was provided to and reviewed by all Massachusetts providers through the ongoing Office of Inspector General (OIG) and Department of Justice (DOJ) joint project;
- requested Blue Cross of Massachusetts and HCFA to review a limited number of cases to determine why these claims were approved for payment;
- requested Blue Cross of Massachusetts' Medical Review to review a limited number of cases to determine admission-relatedness; and
- followed-up on prior findings and recommendations through a joint project with the DOJ.

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.

Our field work was performed from March 1995 through August 1995 at the HCFA Central Office in Baltimore, Maryland; Blue Cross of Massachusetts; Blue Cross of Connecticut; Aetna of Connecticut; selected Massachusetts and Connecticut hospitals; the Office of Audit Services' Regional Office in Boston, Massachusetts; and the Office of Audit Services' Field Office in Hartford, Connecticut.

The draft report was issued to HCFA on January 23, 1996. The HCFA's written comments, dated March 22, 1996, are appended to this report (see Appendix III) and addressed on page 8.

IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES

Under PPS, Medicare FIs reimburse hospitals a predetermined amount for inpatient services furnished to Medicare beneficiaries depending on the illness and its classification under a DRG. It has been HCFA's longstanding policy to treat any nonphysician outpatient services rendered the day before admission, the day of admission, or during the inpatient stay as inpatient services. To curb further unbundling of services which has occurred since the introduction of PPS, the DRG payment window was expanded to include services rendered up to 72 hours prior to admission. We identified a potential of over $27 million in improper billings and subsequent payments for nonphysician outpatient services. In addition, a significant amount of related 20 percent beneficiary coinsurance was improperly charged.

Section 3610.3 of the MIM and section 415.6 of the Medicare Hospital Manual provide regulations specific to the 24-hour rule in that if a beneficiary with Part A coverage is furnished outpatient hospital services and is thereafter admitted as an inpatient of the same hospital, the outpatient hospital services furnished to the beneficiary are treated as inpatient services and are included in the hospital's Part A payment. In incorporating the OBRA '90, sections 3610.3 and 415.6 provide that preadmission diagnostic and admission-related nondiagnostic services rendered up to 72 hours prior to the day of admission are deemed to be inpatient services and are included in the inpatient payment.

Section 3670 of the MIM defines the responsibilities of the FIs for detecting duplicate payments for these services. Specifically, section 3670 states: "Whenever the following claim situations occur the intermediary should develop a way to prevent duplicate payment of claims. This includes:

> 1. Outpatient payment is claimed where the date of service is totally within inpatient dates of service at the same or another provider...
>
> 2. Outpatient bill is submitted for services on the day of an admission or the day before the day of admission to the same hospital."

To determine if the necessary controls are in place, we conducted a series of computer matches of general-care inpatient data to outpatient data utilizing HCFA's National Claims History files for CYs 1992 through 1994. Through these computer applications, we identified over 197,000 potential improper payments. All claims fall into one of three categories (see Figure 1):

- 66,044 claims for services rendered during an inpatient stay - same and different providers;
- 61,105 claims for services rendered on the day of admission - same provider; and

- 70,730 for services rendered up to 72 hours prior to the day of admission - same provider.

The 70,730 claims can be further broken down into the following categories:

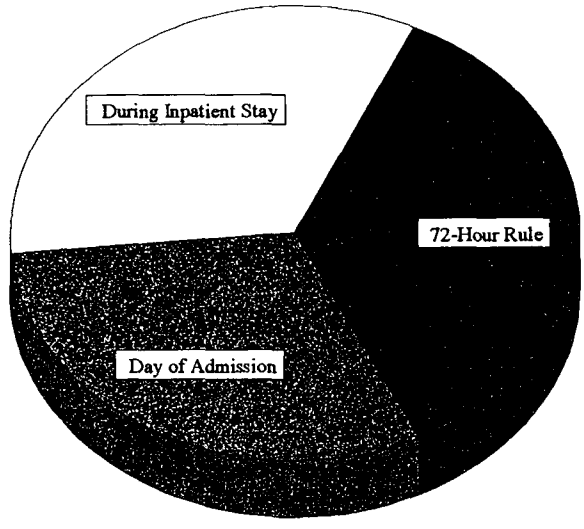

Figure 1 - *Error Types*

- 5,611 claims for services rendered on the day before admission - same provider (applies to all diagnostic and nondiagnostic services rendered prior to August 1, 1992);

- 7,890 claims for diagnostic services only and 13,514 for admission-related nondiagnostic services only;

- 6,012 claims containing both diagnostic and nondiagnostic services and are admission related (based on principal diagnosis codes); and

- 37,703 claims containing both diagnostic and nondiagnostic services (principal diagnosis codes do not agree). In these situations, the payment for the diagnostic services would be in error while the payment for nondiagnostic services would be proper.

As a means of validating the results of the computer applications and also to identify the cause, we judgmentally selected five hospitals located in Massachusetts and Connecticut. At each of the hospitals, we reviewed a number of claims and supporting documentation to determine the appropriateness of the claim. In addition, the CY 1994 data was reviewed by all Massachusetts providers through an ongoing OIG/DOJ joint project. Based on our review of the judgmental sample and the results of the Massachusetts providers' review, the claims identified from the computer match were inappropriately billed and reimbursed. We did not extend our audit work beyond this sample because, in our professional judgement, the results obtained from additional audit work would not have produced different results. We base this conclusion on the results of our four prior reviews from which HCFA has recovered almost all of the overpayments identified through our computer matching. As such, we are confident that the improper payments could be as much as $27,158,452 million (see Appendix II for summary by FI) for CYs 1992 through 1994. In addition, related 20 percent beneficiary coinsurance was improperly charged for those services on which it is applicable.

In discussions with the five hospitals, we determined that these billing errors occurred for three primary reasons:

- ineffective data exchange between inpatient and outpatient departments;
- outpatient hospital was unaware that the patient was an inpatient at another hospital; and
- no hospital system edit to identify admission-related nondiagnostic services (principal diagnosis codes are the same) rendered within the 72-hour payment window.

Irrespective of the fact that hospitals should not submit claims for these services, section 3670 of the MIM relates to the FIs' responsibility for detecting and preventing duplicate claims. Additionally, the CWF system was designed as a prepayment validation system to supplement the FIs' systems to avoid improper payments. To determine why the claims were improperly reimbursed, we requested Blue Cross of Massachusetts to review a limited number of claims representing the various situations as identified in Figure 1. These claims were processed through the FI and the CWF claims processing systems without encountering an edit. The FI agreed that these claims should not have been reimbursed. The FI indicated that its system edits were not sufficient to prevent these duplicate payments but noted that CWF makes the final determination whether to pay or deny a claim. In the FI's opinion, CWF edits had to have been "turned off" since CWF edits can not be overridden.

Since the CWF system makes final determination to pay or deny a claim, we also requested HCFA and Medicare contractor personnel responsible for maintaining the CWF to review these same claims. The CWF maintenance personnel are in agreement with the FI that these claims should not have been reimbursed. The CWF maintenance personnel indicated that 1) two edits were turned-off in 1992 but will be reactivated in November 1995 (mainly for non-PPS hospital claims) and 2) edits were never implemented to preclude separate payment for admission-related nondiagnostic services. The CWF maintenance personnel stated that November 1995 changes to CWF should correct any problems but could not explain why the remaining six edits relative to these claims were not functioning during the period under review.

JOINT RECOVERY PROJECT

Since the inception of PPS in 1983, improper billings and subsequent payments have been made despite Medicare law and regulations which prohibit separate billing and payment for nonphysician outpatient services. This problem was brought to HCFA's attention in four prior OIG reports, and based on recovery actions relative to the first three reports, over $100 million in improper payments have been recovered (see Appendix I). Notwithstanding the corrective actions taken by HCFA, the problem still persists. As such, the OIG has initiated a joint project with the DOJ to recover outstanding overpayments, to assess penalties and interest, and to require hospitals to implement the needed controls.

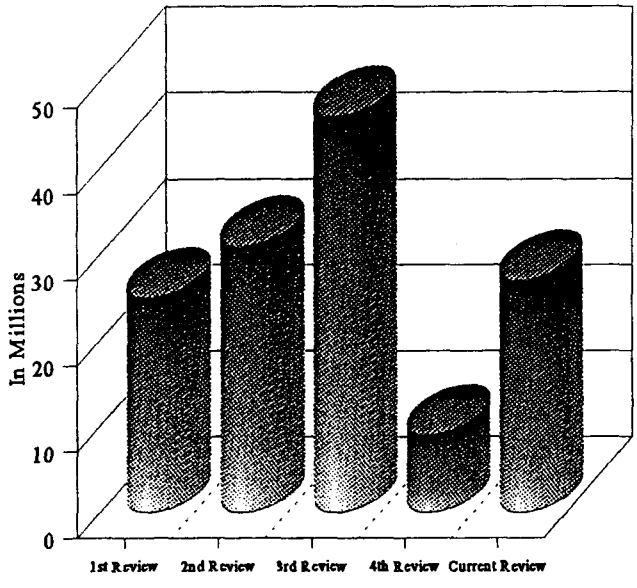

Figure 2 - *Overpayments Identified*

After our fourth report was issued, the OIG initiated a joint project with the DOJ. This joint project, as reported to HCFA in August of 1995 (A-03-94-00021), is intended to achieve three results:

① recover from hospitals any outstanding overpayments and assess penalties and interest on overpayments made since December 1987 (the third review);

② require hospitals to refund amounts owed Medicare beneficiaries for improperly billed coinsurance and deductibles; and

③ require hospitals to establish internal controls to preclude further improper billings for nonphysician outpatient services.

Although HCFA concurred with and implemented most of our recommendations from prior reports, additional measures need to be taken to curb further unbundling of services. The hospital community has continued with its billing practices relying on the FIs and HCFA to detect and prevent improper payments. Since the OIG has demonstrated an improper billing pattern among the hospital community, the claims which we identified are subject to the False Claims Act. The project is underway and will continue recovery on a State by State basis.

CONCLUSION

Hospitals under the PPS submitted claims for and were reimbursed over $27 million for nonphysician outpatient services. The OIG has previously issued four reports addressing these inappropriate payments covering the period October 1983 through December 1991 and identified over $115 million of which $100 million has been recovered. We had expected the amount of inappropriate payments to have significantly curtailed; however, they have not. It is obvious that the needed controls are not in place in both the hospitals' and FIs'/CWF claims processing systems. The joint OIG/DOJ project requires hospitals to implement the necessary controls. Our recommendations are geared toward what HCFA must do to curb further improper payments.

RECOMMENDATIONS

We believe HCFA should:

1. review CWF to ensure all edits are active and, if required, develop edits to address the legislative requirements set forth by OBRA '90; and

2. incorporate into the design of the Medicare Transaction System edits to address all legislative requirements set forth by OBRA '90 which prohibits separate payment for nonphysician outpatient services rendered within the DRG payment window.

HCFA COMMENTS

In response to our draft report, HCFA concurred with both recommendations. The HCFA indicated: (1) that it conducted a review of the CWF and has all appropriate edits turned on and working properly; (2) in compliance with OBRA '90 72 hour legislation, a series of Part A/Part B crossover edits were implemented and updated on November 20, 1995 and January 1, 1996; and (3) CWF will be in complete compliance with OBRA '90 legislation with its July 1, 1996 quarterly release. Lastly, with respect to the MTS edits, HCFA indicated that the MTS workgroup will take our draft report under advisement and design the system accordingly. The HCFA also provided technical comments which we considered and, where necessary, made changes to this final report.

APPENDICES

PRIOR OIG REPORTS ADDRESSING IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES

CIN	TITLE	AUDIT PERIOD	AMOUNT RECOVERED OR IDENTIFIED
A-01-86-62024	Millions in Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System	October 1, 1983 through January 31, 1986	$24.6 million Recovered
A-01-90-00516	Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System	February 1, 1986 through November 30, 1987	$31 million Recovered
A-01-91-00511	Nationwide Review of Improper Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System	December 1, 1987 through October 31, 1990	$45.7 million Recovered
A-01-92-00521	Expansion of the Diagnosis-Related Group Payment Window	November 1, 1990 through December 31, 1991	$8.6 million Identified

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES
JANUARY 1992 THROUGH DECEMBER 1994

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
00010-BC OF ALABAMA	101	5,733	692,396
00020-BC OF ARKANSAS	73	1,862	194,754
00030-BC OF ARIZONA	55	2,741	469,617
00040-BC OF CALIFORNIA	287	5,521	1,108,217
00050-COLORADO HOSPITAL SERVICE	55	860	106,066
00060-BC OF CONNECTICUT	27	1,279	204,366
00070-BC OF DELAWARE	7	495	62,245
00090-BC OF FLORIDA	159	3,841	510,880
00101-BC OF GEORGIA	139	4,799	753,954
00121-HEALTH CARE SERVICE CORP - ILLINOIS	179	8,542	948,896
00123-HEALTH CARE SERVICE CORP - MICHIGAN	92	697	88,007
00130-MUTUAL HOSPITAL INSURANCE INC INDIANA	115	8,041	1,330,852
00140-BC OF IOWA	123	942	122,638
00150-BC OF KANSAS	86	665	76,015
00160-BC OF KENTUCKY	103	4,889	528,518
00180-ASSOCIATED HOSPITAL SERVICE OF MAINE	38	816	87,539
00190-BC OF MARYLAND	9	2,340	495,214
00200-BC OF MASSACHUSETTS	75	4,607	560,415
00210-BC OF MICHIGAN	145	3,693	451,087
00220-BC OF MINNESOTA	133	3,218	370,452
00230-BC OF MISSISSIPPI	137	4,835	471,996
00231-BC OF LOUISIANA	86	7,161	987,754
00241-BC OF HOSPITAL SERVICE OF MISSOURI	115	933	139,777
00250-BC OF MONTANA	19	121	20,508
00260-BC OF NEBRASKA	49	359	44,685
00270-NEW HAMPSHIRE/VERMONT HOSPITAL SERVICE	40	1,505	178,558

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES
JANUARY 1992 THROUGH DECEMBER 1994

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
00280-HOSPITAL SERVICE PLAN OF NEW JERSEY	89	11,431	1,955,026
00290-NEW MEXICO BC	79	2,743	262,639
00308-EMPIRE BC	211	16,072	2,021,100
00310-NORTH CAROLINA BC	114	4,142	591,817
00320-BC OF NORTH DAKOTA	39	384	59,917
00332-HOSPITAL CARE CORP OHIO	176	6,298	753,962
00340-BC OF OKLAHOMA	88	2,088	367,742
00350-NORTHWEST HOSPITAL SERVICE OREGON	57	980	166,873
00351-BC OF IDAHO	35	497	61,808
00362-BC OF GREATER PHILADELPHIA	26	1,712	204,564
00363-BC OF WESTERN PENNSYLVANIA	148	13,453	1,691,392
00370-BC OF RHODE ISLAND	12	790	129,578
00380-BC OF SOUTH CAROLINA	61	1,611	155,333
00390-BC OF TENNESSEE	132	4,889	582,249
00400-BC OF TEXAS	266	4,753	711,057
00410-BC OF UTAH	16	168	21,621
00423-BC OF VIRGINIA	134	7,377	843,945
00430-BC OF WASHINGTON ALASKA	82	1,981	348,345
00450-ASSOCIATED HOSPITAL SERVICE IN WISCONSIN	120	2,459	245,390
00460-WYOMING HOSPITAL SERVICE	11	119	12,652
00468-COOPERATIVA DE SEGUROS DE VIDA DE PUERTO RICO	53	1,221	73,284
17120-HAWAII GUAM MEDICAL SERVICE ASSOCIATION	14	143	24,746
50333-TIC NEW YORK	24	1,353	185,880
51051-AETNA CALIFORNIA	137	3,234	525,707

SUMMARY BY INTERMEDIARY OF POTENTIAL IMPROPER PAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES
JANUARY 1992 THROUGH DECEMBER 1994

INTERMEDIARY	PROVIDER COUNT	CLAIM COUNT	TOTAL PAID AMOUNT
51070-AETNA CONNECTICUT	25	2,862	408,264
51100-AETNA FLORIDA	3	159	32,422
51140-AETNA ILLINOIS	26	896	156,655
51390-AETNA PENNSYLVANIA	43	5,788	942,584
52280-MUTUAL OF OMAHA	381	17,781	2,616,494
TOTAL	4,957	197,879	27,158,452

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administrati

The Administrator
Washington, D.C. 20201

DATE: MAR 22 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General Draft Report "Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services under the Prospective Payment System," (A-01-95-00508)

We reviewed the above-referenced report which examines improper billing and inappropriate payments to cover nonphysician outpatient services.

We concur with the report recommendations. Our specific comments are attached. Additionally, under a separate cover, we offer technical comments concerning the statutory and regulatory text of the report. Thank you for the opportunity to review and comment on this report.

Attachment

Health Care Financing Administration (HCFA) Comments on Office of Inspector General Draft Report: "Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Prospective Payment System," (A-01-95-00508)

OIG Recommendation 1

HCFA should review the Common Working File (CWF) to ensure all edits are active and, if required, develop edits to address the legislative requirements set forth by OBRA 90.

HCFA Response

We concur. HCFA has conducted a review of the CWF and has all appropriate edits turned on and working properly. In compliance with OBRA 90 72-hour legislation, a series of Part A/Part B crossover edits were implemented and updated in CWF on November 20, 1995 and January 1, 1996. Additionally, CWF will be in complete compliance with the OBRA 90 legislation with its July 1, 1996, quarterly release.

OIG Recommendation 2

HCFA should incorporate into the design of the Medicare Transaction System (MTS) edits to address all legislative requirements set forth by OBRA 90 which prohibits separate payment for nonphysician outpatient services rendered within the Diagnostic Related Group payment window.

HCFA Response

We concur. This issue is being addressed by the MTS workgroup which will take this draft report under advisement and design the system accordingly.