Memorandum

Date OCT - 9

From Janet Rehnquist
Inspector General

Subject Review of Rural Health Clinic Medicare Claims for Calendar Years 1997, 1998, and 1999 (A-07-00-00108)

To

Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's final report entitled, "Review of Rural Health Clinic Medicare Claims for Calendar Years 1997, 1998, and 1999." The objectives of our audit were to determine whether: (1) Part B claims were paid for the same services that were covered by, and paid as part of, rural health clinic (RHC) encounter claims; and (2) duplicate RHC encounter claims were paid for services provided to the same beneficiaries, for the same dates of service, and with the same diagnoses.

The encounter claims for RHC services are paid on the basis of an all-inclusive rate per visit. Independent RHCs' encounter claims are paid by RHC designated fiscal intermediaries (FI) and claims for non-RHC items and services are paid by RHCs' local carriers. For provider-based RHCs, both RHC encounter claims and claims for non-RHC items and services are paid by the providers' FIs.

For 13 selected States, we identified claims containing potential Medicare overpayments totaling $2,762,969, as follows:

- $2,560,258 in Part B claims for services that were covered by, and paid as part of, RHC encounter claims; and

- $202,711 in duplicate RHC encounter claims paid for services provided to the same beneficiaries, for the same dates of service, and with the same diagnoses.

In addition, $1,324,960 in beneficiary deductible and coinsurance were associated with the duplicate services on the Part B claims containing potential overpayments. Deductible and coinsurance are unreimbursed expenses that beneficiaries are required to pay.

Previously, the Centers for Medicare & Medicaid Services (CMS) issued guidance that required coordination and claims data exchange between RHC designated FIs and carriers to prevent duplicate payments for services that were included in, and paid as part of, RHC

encounter claims. We were advised by officials of the RHC designated FI we visited that there are currently no requirements for such coordination and claims data exchange.

Currently, FIs and carriers process claims against the Common Working File (CWF) Master Record prior to payment. Since this record contains all of the elements needed to detect the types of potential overpayments noted in our review, we believe that effective CWF edits could accomplish what the previous requirements for FI and carrier coordination and computer edits were designed to do.

We recommended that CMS:

- Design and implement CWF edits to detect claims which contain Part B services that were paid as, or as part of, RHC encounter claims.

- Reestablish the requirements for coordination and computer system edits for FIs and carriers to detect Part B services that were paid as part of RHC encounter claims, until CWF edits are implemented.

- Require FIs to develop effective procedures and computer system edits to detect the submission of duplicate RHC encounter claims.

- Instruct FIs and carriers to recover overpayments made for Part B services that were paid as part of RHC encounter claims as well as duplicate RHC encounter claims during Calendar Years (CY) 1997, 1998, and 1999.

- Direct carriers to instruct RHCs, physicians, and non-physician practitioners employed by them, to refund to the beneficiaries any Part B deductible and/or coinsurance collected related to the identified overpayments made on duplicate Part B claims for RHC services during CYs 1997, 1998, and 1999.

The CMS agreed with all of our recommendations except for designing and implementing CWF edits. The CMS believed that this recommendation would result in additional administrative burdens as it would require RHCs to list individual procedure codes for each service provided. While we appreciate CMS's concern, during the audit we identified potential overpayments using the same information contained in CWF without requiring RHCs to list individual procedure codes. Accordingly, we believe that CWF edits would be the most effective way to correct the problems found during the audit, without placing additional administrative burdens on RHCs. The CMS's comments are included in their entirety as APPENDIX E.

We would also appreciate the status of any action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-07-00-00108 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF RURAL HEALTH CLINIC MEDICARE CLAIMS FOR CALENDAR YEARS 1997, 1998, AND 1999

JANET REHNQUIST
INSPECTOR GENERAL

OCTOBER 2001
A-07-00-00108

Memorandum

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From Janet Rehnquist
Inspector General

Subject Review of Rural Health Clinic Medicare Claims for Calendar Years 1997, 1998, and 1999 (A-07-00-00108)

To Thomas Scully
Administrator
Centers for Medicare & Medicaid Services

This final report provides you the results of our "Review of Rural Health Clinic Medicare Claims for Calendar Years 1997, 1998, and 1999." Specifically, we reviewed rural health clinic (RHC) claims to determine whether: (1) Part B claims were paid for the same services that were covered by, and paid as part of, RHC encounter claims; and (2) duplicate RHC encounter claims were paid for services provided to the same beneficiaries, for the same dates of service, and with the same diagnoses.

The encounter claims for RHC services are paid on the basis of an all-inclusive rate per visit. Independent RHCs' encounter claims are paid by RHC designated fiscal intermediaries (FI) and claims for non-RHC items and services are paid by RHCs' local carriers. For provider-based RHCs, both RHC encounter claims and claims for non-RHC items and services are paid by the providers' FIs.

For 13 selected States, we identified claims containing potential Medicare overpayments totaling $2,762,969, as follows:

- $2,560,258 in Part B claims for services that were covered by, and paid as part of, RHC encounter claims; and
- $202,711 in duplicate RHC encounter claims paid for services provided to the same beneficiaries, for the same dates of service, and with the same diagnoses.

In addition, $1,324,960 in beneficiary deductible and coinsurance were associated with the duplicate services on the Part B claims containing potential overpayments. Deductible and coinsurance are unreimbursed expenses that beneficiaries are required to pay.

Previously, the Centers for Medicare & Medicaid Services (CMS), issued guidance that required coordination and claims data exchange between RHC designated FIs and carriers to prevent Part B payments for services that were covered by, and paid as part of, RHC

encounter claims. We were advised by officials of the RHC designated FI we visited that there are no current requirements for such coordination and claims data exchange.

Currently, FIs and carriers process claims against the Common Working File (CWF) Master Record prior to payment. Since this record contains all of the elements needed to detect the potential overpayments noted in our review, effective CWF edits could accomplish what the previous requirements for FI and carrier coordination and computer edits were designed to do.

We recommended that CMS:

- Design and implement CWF edits to detect claims which contain Part B services that were paid as, or as part of, RHC encounter claims.

- Reestablish the requirements for coordination and computer system edits for FIs and carriers to detect Part B services that were paid as part of RHC encounter claims, until CWF edits are implemented.

- Require FIs to develop effective procedures and computer system edits to detect the submission of duplicate RHC encounter claims.

- Instruct FIs and carriers to recover overpayments made for Part B services that were paid as part of RHC encounter claims as well as duplicate RHC encounter claims during Calendar Years (CY) 1997, 1998, and 1999.

- Direct carriers to instruct RHCs, physicians, and non-physician practitioners employed by them, to refund to the beneficiaries any Part B deductible and/or coinsurance collected related to the identified overpayments made on duplicate Part B claims for RHC services during CYs 1997, 1998, and 1999.

The CMS agreed with all of our recommendations except for designing and implementing CWF edits. The CMS believed that this recommendation would result in additional administrative burdens as it would require RHCs to list individual procedure codes for each service provided. While we appreciate CMS's concern, during the audit we identified potential overpayments using the same information contained in CWF without requiring RHCs to list individual procedure codes. Accordingly, we believe that CWF edits would be the most effective way to correct the problems found during the audit, without placing additional administrative burdens on RHCs. We have coordinated with CMS officials to provide them with detailed information to facilitate the recovery of the overpayments identified by our review. The CMS's comments are included in their entirety as APPENDIX E.

Background

The Rural Health Clinics Act (Act) was passed by Congress in 1977 and implemented in 1978. The purpose of the Act was to address an inadequate supply of physicians who serve Medicare beneficiaries and Medicaid recipients in rural areas. The Act addressed this issue by expanding reimbursement in the RHC setting to include services provided by non-physician practitioners.

The 42 CFR 405.2462 sets forth payment methodologies for two types of RHCs, independent and provider-based, that provide two types of services, RHC services and non-RHC services. These services are paid through either an FI or a carrier depending upon the type of RHC and the type of service as shown in the chart below:

Type of RHC	Type of Services	Paid Through
Independent	RHC Services	RHC's Designated FI
Independent	Non-RHC Services	RHC's Local Carrier
Provider-based	RHC Services	Provider's FI
Provider-based	Non-RHC Services	Provider's FI

Independent RHCs are free-standing practices that are not part of a hospital, skilled nursing facility (SNF), or home health agency (HHA). Their claims for non-RHC services are paid by their local carriers. Their encounter claims for RHC services are paid by RHC designated FIs. Currently, CMS has contracted with five FIs to monitor, process, and pay claims for independent RHCs: Riverbend Government Benefits Administrator in Chattanooga, Tennessee; Blue Cross and Blue Shield of New Hampshire in Manchester, New Hampshire; Associated Hospital Service of Maine in Portland, Maine; Trailblazer Health Enterprises in Dallas, Texas; and Veritus Medicare Services in Pittsburgh, Pennsylvania.

Provider-based RHCs are an integral and subordinate part of a hospital, SNF, or HHA, and are operated with other departments under common licensure, governance, and professional supervision. Their encounter claims for RHC services, as well as claims for non-RHC services, are paid by a provider's FI.

Encounter claim payments to independent and provider-based RHCs are made on the basis of an all-inclusive rate per visit for covered RHC services provided to Medicare beneficiaries. The term visit is defined as a face-to-face encounter between the patient and physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker. Encounters with more than one health professional and multiple encounters with the same health professional

that take place on the same day and at a single location constitute a single visit. The only exception to the single visit rule is for cases in which the patient, subsequent to the first encounter, suffers an illness or injury requiring additional diagnosis or treatment.

In general, RHC services covered in an encounter claim include: physician services; services and supplies incident to physician services; nurse practitioner and physician assistant services that would be covered if furnished by a physician; services and supplies incident to the services of nurse practitioners and physician assistants that would be covered if furnished incident to a physician's services; visiting nurse services to the homebound, under special circumstances; clinical psychologist and clinical social worker services; and services and supplies incident to the services of clinical psychologists and clinical social workers.

Physicians' services provided in RHCs are defined in 42 CFR 405.2412 (a):

> "Physicians' services are professional services that are performed by a physician at the clinic or are performed away from the clinic by a physician whose agreement with the clinic provides that he or she will be paid by the clinic for such services."

Services and supplies incident to a physician's services provided in RHCs are defined in 42 CFR 405.2413:

> "(a) Services and supplies incident to a physician's professional service are reimbursable under this subpart if the service or supply is:
> (1) Of a type commonly furnished in physicians' offices;
> (2) Of a type commonly rendered either without charge or included in the rural health clinic's bill;
> (3) Furnished as an incidental, although integral, part of a physician's professional services;
> (4) Furnished under the direct, personal supervision of a physician; and
> (5) In the case of a service, furnished by a member of the clinic's health care staff who is an employee of the clinic."

According to section 2260.2 of part 3 of the Medicare Carrier Manual (MCM) and section 402 of the Rural Health Manual, non-RHC services include: durable medical equipment; ambulance services; prosthetic devices; leg, arm, back, and neck braces; artificial legs, arms, and eyes; arranging of physical, speech, or occupational therapy with suppliers not employed by the RHC; the technical component of diagnostic tests such as x-rays and electrocardiograms; and screening mammography services. Laboratory services, excluding the six basic laboratory tests required for RHC certification, which are performed in a certified Medicare laboratory are also considered non-RHC services.

Medicare payment for RHC services begins only after the beneficiary has incurred the annual deductible of the first $100 of expenses during any CY for Part B covered items and

services. The beneficiary is also responsible for a coinsurance amount, not to exceed 20 percent of the clinic's reasonable and customary charge for the covered service. The beneficiary's deductible and coinsurance liability, with respect to items or services furnished by the RHC, may not exceed a reasonable amount customarily charged by the clinic for the covered item or service.

As part of CMS's claims processing procedures, FIs and carriers process all claims, including RHC encounter claims and other Part B claims, against the CWF Master Record prior to payment. All Part A and Part B claims for a beneficiary are processed against a single file, called the CWF Master Record, in one of nine localized databases called Hosts, prior to claims payment. This record contains complete entitlement, utilization, and history data, as well as deductible information, for each beneficiary.

Scope and Methodology

Our audit was conducted in accordance with generally accepted government auditing standards except that the review objectives did not require an understanding or an overall assessment of the internal control structure of RHCs or CMS.

We reviewed Medicare requirements, gathered additional information, and determined the specific rules for RHCs. To clarify the requirements, we analyzed data that focused on two areas with potential for duplicate payments for RHC services: (1) Part B claims for services that were covered by, and paid as part of, RHC encounter claims; and (2) duplicate RHC encounter claims.

As a basis for selecting States for our audit, we used CMS's Customer Information System to obtain Medicare payments to RHCs by State for CYs 1997, 1998, and 1999. The 13 States with the highest total dollar amount paid to all RHCs were selected for data analysis. Those States were Texas, Kansas, Illinois, Mississippi, California, Michigan, Missouri, Florida, Iowa, North Carolina, Virginia, South Carolina, and Arkansas.

For the selected States, we extracted RHC encounter claims for CYs 1997, 1998, and 1999 from CMS's National Claims History (NCH) paid claims file. There were 11 million such claims totaling $470 million. We also extracted from NCH all other Part B claims for the same beneficiaries that had encounter claims.

To identify Part B claims that were paid for the same services that were covered by, and paid as part of, RHC encounter claims, we performed computer analyses. The computer analyses matched the RHC encounter claims file with the Part B claims file based on beneficiary health insurance claim number (HICN), date of service, and performing physician and non-physician practitioner unique physician identification number (UPIN). For Part B claims with potential overlapping services, we determined the amount paid for services provided that were also covered by, and paid as part of, an RHC encounter claim. We also visited two RHCs - one independent and one provider-based - where we reviewed

selected Part B claims and their matched encounter claims in order to verify the results of our data analyses. To identify duplicate RHC encounter claims, we extracted those RHC encounter claims that included encounter revenue codes and performed a computer match on the extracted claims. We matched encounter claims based on RHC provider number, beneficiary HICN, date of service, and diagnosis. We considered duplicate claims to be those that matched on these four fields.

Our field work was performed at an RHC designated FI in Chattanooga, Tennessee; two RHCs in Troy and Louisiana, Missouri; and our field office in Jefferson City, Missouri.

RESULTS OF REVIEW

Our review showed more than $2.7 million in potential Medicare overpayments. Potential overpayments of $2,560,258 related to Part B services that were covered in, and paid as part of, RHC encounter claims for the same beneficiaries, with the same dates of service, and provided by the same physicians. An additional $202,711 in potential overpayments related to duplicate encounter claims for which RHCs had been paid twice for the same beneficiaries, with the same dates of service, and with the same diagnoses.

We determined that beneficiary deductible and coinsurance of $1,324,960 related to the Part B potential overpayments. The deductible and coinsurance amount was obtained from CMS's NCH paid claims file. Deductible and coinsurance are unreimbursed expenses that beneficiaries are required to pay.

Review of RHC/Part B Claims

In our computer analysis, we identified 94,727 Part B claims which contained potential overpayments totaling $2,560,258. These overpayments were for Part B claims that included services covered and paid as part of RHC encounter claims. The Part B claims which were paid by carriers included services for the same beneficiaries, with the same dates of service, and provided by the same physicians as encounter claims paid by FIs. See APPENDIX A for a schedule of the Part B claims that include services which were also covered by, and paid as part of, RHC encounter claims.

The Part B procedures that were paid for by carriers as well as covered by, and paid as part of, RHC encounter claims are summarized below:

Type of Procedure	CPT Procedure Code Ranges	Number of Procedures	Amount Paid By Part B
Medicine (except Anesthesiology)*	90375-99195	48,798	$1,036,443
Radiology*	70030-78596	31,483	647,311
Surgery	10040-69222	11,892	351,090
Injection of Various Drugs	J0120-J7320 J9020-J9999 Q0136 Q9924-Q9936	10,795	290,124
Physician Visits	99201-99376	7,441	163,722
Procedures/Services – Temporary	G0002-G0053 Q0091-Q0111 Q0162, Y3102, Z2003	6,955	62,085
Laboratory/Pathology (required basic lab tests)	81002, 81025, 82270, 82962, 83026	2,259	8,375
Supplies	A4353-A6252	32	1,108
Total		119,655	$2,560,258

*** only the technical component should have been billed**

We were advised by officials of an RHC designated FI in Chattanooga, Tennessee, Riverbend Government Benefits Administrator, that there are currently no requirements for coordination between RHC designated FIs and carriers to detect claims which contained duplicate services. Previously, CMS had issued guidance (section 3642.1 of part 3 of the Medicare Intermediary Manual (MIM) and sections 9202D and 9204 of part 3 of the MCM) that required the RHC designated FIs and carriers to coordinate and exchange claims data to prevent duplicate payments.

However, in a May 1995 MIM revision transmittal, CMS informed FIs that the coordination and data exchange were no longer necessary. The MIM, but not the MCM, was revised and the requirement was removed.

Currently, Part A and Part B claims are processed against the CWF Master Record prior to claims payment. This record contains complete entitlement, utilization, and history data, as well as deductible and coinsurance information, for each beneficiary. Since this record contains all the elements needed to detect the potential overpayments noted in our review, effective CWF edits could accomplish what the previous requirements for FI and carrier coordination and computer edits were designed to do.

Review of Duplicate RHC Encounter Claims

In our analysis of RHC encounter claims, we also identified 5,815 duplicate claims resulting in potential Medicare overpayments totaling $202,711. These duplicate claims consisted of RHCs billing for more than one encounter for the same beneficiaries, with the same dates of service, and with the same diagnoses. See APPENDIX B for a detailed schedule.

According to section 504 of the RHC Manual, a visit is defined as:

> "...a face to face encounter between the patient and a physician, physician assistant, nurse practitioner, nurse midwife, specialized nurse practitioner, visiting nurse, clinical psychologist, or clinical social worker during which a RHC...service is rendered...Encounters with more than one health professional and multiple encounters with the same health professional which take place on the same day and at a single location constitute a single visit, except for cases in which the patient, subsequent to the first encounter, suffers illness or injury requiring additional diagnosis or treatment."

The RHCs may not bill for more than one encounter for a beneficiary on the same date, unless there is a different diagnosis.

Deductibles and Coinsurance Related to Part B Potential Overpayments

Medicare payment for RHC services begins only after the beneficiary has incurred the annual deductible of the first $100 of expenses during any CY for Part B covered items and services. The beneficiary is also responsible for a coinsurance amount not to exceed 20 percent of the clinic's reasonable and customary charge for the covered service. The beneficiary's deductible and coinsurance liability, with respect to items or services furnished by the RHC, may not exceed a reasonable amount customarily charged by the clinic for the covered item or service.

Our analysis of paid claims further identified $580,975 in deductibles (see APPENDIX C for a detailed schedule) and $743,985 in coinsurance (see APPENDIX D for a detailed schedule) on the Part B claims containing potential overpayments during the 3-year period. Deductible and coinsurance are unreimbursed expenses that beneficiaries are required to pay.

CONCLUSIONS AND RECOMMENDATIONS

We believe that effective CWF edits could be designed to detect claims duplicating RHC services already paid and that, if implemented, could resolve the issues raised in this report. In addition, we believe that CWF edits could prevent beneficiaries from paying twice for deductible and/or coinsurance amounts. We also have coordinated with CMS officials to provide them with detailed information to facilitate the recovery of the overpayments identified by our review.

Recommendations

We recommended that CMS:

- Design and implement CWF edits to detect claims which contain Part B services that were paid as, or as part of, RHC encounter claims.

- Reestablish the requirements for coordination and computer system edits for FIs and carriers to detect Part B services that were paid as part of RHC encounter claims, until CWF edits are implemented.

- Require FIs to develop effective procedures and computer system edits to detect the submission of duplicate RHC encounter claims.

- Instruct FIs and carriers to recover overpayments made for Part B services that were paid as part of RHC encounter claims as well as duplicate RHC encounter claims during CYs 1997, 1998, and 1999.

- Direct carriers to instruct RHCs, physicians, and non-physician practitioners employed by them, to refund to the beneficiaries any Part B deductible and/or coinsurance collected related to the identified overpayments made on duplicate Part B claims for RHC services during CYs 1997, 1998, and 1999.

CMS's Comments

The CMS agreed that there exists a potential for duplicate payments for services performed by RHC staff. However, CMS stated that addressing this issue may be more complicated than it would appear from our report. With respect to the specific recommendations, CMS concurred with all of our recommendations except that they did not concur to design and implement CWF edits because:

> "This would require RHCs to list individual HCFA Common Procedure Coding System (HCPCS) codes for each service provided. HCPCS coding would place an additional administrative burden on RHCs."

In addition, CMS noted that it had issued a proposed rule that would make clear that RHCs are prohibited from sharing their staff, space, and resources with other Medicare provider/practitioners. The CMS also acknowledged the need to improve methods for detecting and recovering overpayments with the RHC setting. The full text of CMS's comments is included as APPENDIX E to this report.

OIG's Response

We can appreciate CMS's concern that implementing our recommendation to design and implement CWF edits would place an administrative burden on RHCs. However, using the same information contained in CWF, we found--**without requiring RHCs to list individual procedure codes--**the potential Part B overpayments by matching Part B line items with RHC encounter claims based on the beneficiary number, date of service, and UPIN. By implementing the edits in CWF, **no additional information would need to be submitted by RHCs.** Also, once CWF edits are in place, the coordination efforts between carriers and FIs could be reduced. Accordingly, we believe our recommendation regarding CWF edits would correct, with minimum cost, the problems found during our audit and would avoid placing additional administrative burdens on RHCs.

In its technical comments, CMS raised several issues it believed needed to be clarified. The CMS is concerned that our report implies that non-RHC services are an integral part of RHCs. However, our report states that **non-RHC items and services** are paid by RHCs' local carriers or the providers' FIs. This statement was included to show that there are services for which RHCs are allowed to bill the carrier that are outside the realm of the encounter claim. Furthermore, during our review we found that RHCs, as well as RHC physicians, submit Part B claims to carriers.

We have modified this final report to take into account CMS's remaining technical comments to our draft report.

APPENDICIES

APPENDIX A

RURAL HEALTH CLINICS

THIRTEEN LARGEST STATES

PART B CLAIMS FOR SERVICES

INCLUDED IN THE RHC ENCOUNTER RATE

FOR THE PERIOD

JANUARY 1, 1997 THROUGH DECEMBER 31, 1999

State	1997	1998	1999*	Total
Arkansas	$ 10,007	$ 25,470	$ 16,851	$ 52,328
California	11,766	19,655	13,327	44,748
Florida	34,943	40,613	40,998	116,554
Illinois	65,242	165,580	95,477	326,299
Iowa	15,004	18,410	8,491	41,905
Kansas	100,145	243,250	139,148	482,543
Michigan	83,847	90,085	64,479	238,411
Mississippi	17,865	51,310	44,811	113,986
Missouri	15,548	26,421	14,632	56,601
North Carolina	17,030	37,398	18,431	72,859
South Carolina	41,836	170,997	41,668	254,501
Texas	114,801	240,225	145,053	500,079
Virginia	45,532	119,118	94,794	259,444
Total	$573,566	$1,248,532	$738,160	$2,560,258

* The 1999 RHC and Part B data was not complete when the data was extracted.

APPENDIX B

RURAL HEALTH CLINICS

THIRTEEN LARGEST STATES

MULTIPLE ENCOUNTER CLAIMS

FOR THE PERIOD

JANUARY 1, 1997 THROUGH DECEMBER 31, 1999

State	1997	1998	1999*	Total
Arkansas	$ 4,773	$ 2,858	$ 2,137	$ 9,768
California	6,421	4,948	3,227	14,596
Florida	9,929	1,775	847	12,551
Illinois	10,491	2,937	606	14,034
Iowa	11,525	1,892	671	14,088
Kansas	5,311	1,726	5,255	12,292
Michigan	7,502	5,731	1,054	14,287
Mississippi	15,018	5,262	238	20,518
Missouri	10,369	9,876	9,988	30,233
North Carolina	4,505	736	395	5,636
South Carolina	7,431	233	432	8,096
Texas	14,891	10,967	9,311	35,169
Virginia	5,542	5,214	687	11,443
Total	$113,708	$54,155	$34,848	$202,711

* The 1999 RHC and Part B data was not complete when the data was extracted.

APPENDIX C

RURAL HEALTH CLINICS

THIRTEEN LARGEST STATES

BENEFICIARIES' DEDUCTIBLE OBLIGATIONS

FOR THE PERIOD

JANUARY 1, 1997 THROUGH DECEMBER 31, 1999

State	1997	1998	1999*	Total
Arkansas	$ 9,032	$ 5,587	$ 3,344	$ 17,963
California	1,330	2,571	2,195	6,096
Florida	12,614	9,850	5,792	28,256
Illinois	31,316	34,566	30,583	96,465
Iowa	5,056	4,775	2,140	11,971
Kansas	48,448	44,245	29,207	121,900
Michigan	27,763	32,160	19,710	79,633
Mississippi	10,716	6,583	9,873	27,172
Missouri	7,015	6,930	3,396	17,341
North Carolina	5,929	5,075	2,207	13,211
South Carolina	12,594	14,043	8,615	35,252
Texas	24,153	31,761	22,961	78,875
Virginia	17,344	14,575	14,921	46,840
Total	$213,310	$212,721	$154,944	$580,975

* The 1999 RHC and Part B data was not complete when the data was extracted.

APPENDIX D

RURAL HEALTH CLINICS

THIRTEEN LARGEST STATES

BENEFICIARIES' CO-INSURANCE OBLIGATIONS

FOR THE PERIOD

JANUARY 1, 1997 THROUGH DECEMBER 31, 1999

State	1997	1998	1999*	Total
Arkansas	$ 2,471	$ 6,034	$ 4,009	$ 12,514
California	2,795	4,925	3,474	11,194
Florida	8,602	9,803	10,166	28,571
Illinois	16,546	42,146	24,559	83,251
Iowa	3,729	4,587	2,116	10,432
Kansas	28,648	105,058	63,494	197,200
Michigan	19,690	21,345	15,131	56,166
Mississippi	4,427	12,812	11,141	28,380
Missouri	4,068	8,532	5,033	17,633
North Carolina	5,155	14,366	6,851	26,372
South Carolina	10,768	56,037	18,579	85,384
Texas	27,167	58,141	36,093	121,401
Virginia	12,325	29,611	23,551	65,487
Total	$146,391	$373,397	$224,197	$743,985

* The 1999 RHC and Part B data was not complete when the data was extracted.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
ashington, D.C. 20201

DATE: JUL 25 2001

TO: Michael F. Mangano
Acting Inspector General
Office of Inspector General

FROM: Ruben J. King-Shaw, Jr.
Deputy Administrator and Chief Operating Officer
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "*Review of Rural Health Clinic Medicare Claims for Calendar Years 1997, 1998, and 1999*" (A-07-00-00108)

Thank you for the opportunity to review and comment on the above-referenced draft report. We appreciate OIG's efforts to determine: whether Part B claims were paid for the same services that were covered by, and paid as part of, rural health clinic (RHC) encounter claims; and whether duplicate RHC encounter claims were paid for services provided to the same beneficiaries, for the same dates of service, and with the same diagnoses. We look forward to working with OIG on this and other issues pertinent to RHC Medicare claims.

The Centers for Medicare & Medicaid Services (CMS) agrees that there exists a potential for duplicate payments for services performed by RHC staff. However, addressing this issue may be more complicated than it would appear from your report. Our responses to the recommendations highlight such complexities.

Our specific comments are as follows:

OIG Recommendation

Design and implement common working file (CWF) edits to detect claims which contain Part B services that were paid as, or as part of, RHC encounter claims.

CMS Response

We non-concur. This would require RHCs to list individual HCFA Common Procedure Coding System (HCPCS) codes for each service provided. HCPCS coding would place an additional administrative burden on RHCs. When Congress legislated the RHC benefit, the associated House Report No. 95-548—Part I, pp. 4060-4061 reported that the intent was to allow " . . . the Secretary maximum flexibility in determining the most efficient reimbursement method given the unique nature of these clinics. Since these clinics are generally very small—perhaps employing as few as three individuals—and use relatively unsophisticated accounting methods, it would impose an undue hardship to mandate the same extensive cost reporting requirements

imposed on hospitals and other health care facilities participating in the Medicare program. The bill allows the Secretary the options of developing a simple reimbursement mechanism based on the actual costs which are incurred by the clinic; using a prospective method of reimbursement such as an all-inclusive rate per visit, which is related to cost; or using any other method that is determined to be reasonable and equitable in this situation." We believe a more workable approach is described in our response to the next recommendation.

OIG Recommendation

Reestablish the requirements for coordination and computer systems edits for fiscal intermediaries (FIs) and carriers to detect Part B services that were paid as part of RHC encounter claims, until CWF edits are implemented.

CMS Response

We concur that this is a proper recommendation. This requirement would require a substantial increase in funding for the Medicare Contractor Budget, as well as system changes that could only be achieved at the expense of competing priorities. However, we will quantify the total resource costs for implementation in order to support a request for additional resources.

OIG Recommendation

Require FIs to develop effective procedures and computer systems edits to detect the submission of duplicate RHC encounter claims.

CMS Response

We concur that this is a proper recommendation. However, we have already taken steps to improve the FIs' claims processing systems. For example, in 2000, we directed the standard claims processing systems to ensure that the duplicate claim edits were "hard coded" into the systems. Hence, the duplicate edits in the FI and carrier systems have been improved since the claims studied by the OIG were processed. To further strengthen duplicate editing, we will consider refining the CWF edits to better detect exact duplicate claims. We will also assess the existing edits aimed at preventing payments for duplicate services in the individual Medicare FI systems. We will continue to assess the existing criteria for duplicate editing in the FI standard systems and will seek additional funding as needed to implement further improvements.

OIG Recommendation

Instruct FIs and carriers to recover overpayments made for Part B services that were paid as part of RHC encounter claims during calendar years (CYs) 1997, 1998, and 1999.

CMS Response

We concur. After issuance of the final report, we look forward to OIG furnishing the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the Medicare contractors to initiate and complete recovery action. Upon receipt of this information, we will forward the final report and the information needed by the Medicare contractors to recover the RHC overpayments to the regional offices for appropriate action.

OIG Recommendation
Direct carriers to instruct RHCs, physicians, and non-physician practitioners employed by them, to refund to the beneficiaries any Part B deductible and/or coinsurance collected related to the identified overpayments made on duplicate Part B claims for RHC services during CYs 1997, 1998, and 1999.

CMS Response
We concur. Once we have identified and recovered any overpayments, the RHCs will be instructed to refund to beneficiaries any refund due on the Part B deductible and/or coinsurance collected in relation to the overpayment.

In addition, we have the following general comments:

Although program dollars are of paramount importance, the data showing the actual number of claims identified as potential duplicates may be more revealing, particularly the data on multiple encounter claims. The information could help us to better identify areas for CMS's routine auditing efforts.

Finally, we would note that CMS issued a proposed rule (February 28, 2000), that would make clear that RHCs are prohibited from sharing their staff, space, and resources with other Medicare provider/practitioners, in order to reduce the opportunity for duplicate Medicare payments. Although this proposed rule would establish strong anti-commingling policy, we also acknowledge the need to improve our methods for detecting and recovering overpayments with the RHC setting.

Attachment

Technical Comments

1. In the cover letter, as well as throughout the report, OIG states that non-RHCs are paid by the RHCs' local carrier or the providers' Fls. This statement seems to imply that these services are an integral part of the RHC, which is not true. OIG should clarify that these services are being rendered by practitioners/providers that are separate and distinct from the RHC in terms of Medicare participation. For example, an RHC may have an independent laboratory or a private Part B physician attached to it.

2. With respect to the RHC definition conveyed in the report, OIG should point out that visiting nurse services to homebound patients are only covered under special circumstances. OIG implies that they are covered without any additional terms or conditions.

3. The definition for services covered and paid outside the RHC benefit is incomplete. For example, laboratory services, i.e., x-rays and electrocardiograms, are not listed. OIG should clarify that the list is not inclusive.

4. The Part B procedure chart should clarify that it refers only to the professional services of physicians and non-physicians.