DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

July 28, 2010

TO: Donald Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

/Joe Green/ for
FROM: George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Year 2007 (A-01-09-00503)

The attached final report provides the results of our review of place-of-service coding for physician services processed by Medicare Part B carriers during calendar year 2007.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov. Please refer to report number A-01-09-00503 in all correspondence.

Attachment

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PLACE-OF-SERVICE CODING FOR PHYSICIAN SERVICES PROCESSED BY MEDICARE PART B CARRIERS DURING CALENDAR YEAR 2007

Daniel R. Levinson
Inspector General

July 2010
A-01-09-00503

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Medicare Part B pays for services that physicians provide to program beneficiaries. Although physicians routinely perform many of these services in a hospital outpatient department or a freestanding ambulatory surgical center (ASC), some of these services may also be performed in nonfacility settings, such as a physician's office, an urgent care center, or an independent clinic. To account for the increased overhead expense that physicians incur by performing services in nonfacility locations, Medicare reimburses physicians at a higher rate for certain services performed in these locations. However, when physicians perform these same services in facility settings, such as hospital outpatient departments or ASCs, Medicare reimburses the overhead expenses to the facility and the physician receives a lower reimbursement rate.

Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the payment if the service was performed in a facility setting.

Our audit covered 484,218 nonfacility-coded physician services valued at $42,385,710 that were provided in calendar year 2007 and that matched hospital outpatient or ASC claims for the same type of service provided to the same beneficiary on the same day.

OBJECTIVE

The objective of our audit was to determine whether physicians correctly coded nonfacility places of service on selected Part B claims submitted to and paid by Medicare contractors.

SUMMARY OF FINDING

Physicians did not always correctly code nonfacility places of service on Part B claims submitted to and paid by Medicare contractors. Physicians correctly coded the claims for 10 of the 100 services that we sampled. However, physicians incorrectly coded the claims for 90 sampled services by using nonfacility place-of-service codes for services that were actually performed in hospital outpatient departments or ASCs. The incorrect coding resulted in overpayments totaling $4,710.

Based on these sample results, we estimated that Medicare contractors nationwide overpaid physicians $13.8 million for incorrectly coded services provided during calendar year 2007. We attribute the overpayments to internal control weaknesses at the physician billing level and to insufficient postpayment reviews at the Medicare contractor level to identify potential place-of-service coding errors.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services (CMS) instruct its Medicare contractors to:

- recover the $4,710 in overpayments for the sampled services;

- immediately reopen the claims associated with the 484,118 nonsampled services, review our information on these claims (which have estimated overpayments of $13,761,858), and work with the physicians who provided the services to recover any overpayments;

- continue to strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes; and

- continue to work with program safeguard contractors and, if necessary to coordinate Part A and Part B data matches, with other Medicare contractors to (1) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. CMS requested that we provide the data necessary to recover overpayments for the sampled and nonsampled services. With respect to the nonsampled services, CMS stated that it would review the most appropriate claims based on the cost-effectiveness of the review. CMS's comments are included in their entirety as Appendix D.

We will provide CMS with the requested data.

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INTRODUCTION

BACKGROUND

Medicare Part B Payments for Physician Services

Medicare Part B pays for services that physicians provide to program beneficiaries. Physician services include medical and surgical procedures, office visits, and medical consultations. These services may be provided in facility settings, such as hospital outpatient departments and freestanding ambulatory surgical centers (ASC), or in nonfacility locations, such as physician offices, urgent care centers, and independent clinics.

Physicians are paid for services according to the Medicare physician fee schedule. This schedule is based on a payment system that includes three major categories of costs required to provide physician services: practice expense, physician work, and malpractice insurance.

Medicare Reimbursement for Practice Expense

Practice expense reflects the overhead costs involved in providing a service. To account for the increased practice expense that physicians generally incur by performing services in their offices and other nonfacility locations, Medicare reimburses physicians at a higher rate for certain services performed in these locations rather than in a hospital outpatient department or an ASC. Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare contractors. The correct place-of-service code ensures that Medicare does not incorrectly reimburse the physician for the overhead portion of the service if the service was performed in a facility setting.

Medicare claim form instructions specifically state that each provider or practitioner is responsible for becoming familiar with Medicare coverage and billing requirements. Some physician offices submit their own claims to Medicare; other offices hire billing agents to submit their claims. Physicians are responsible for any Medicare claims submitted by billing agents.

Medicare Contractors

Historically, Medicare Part B carriers, under contract with the Centers for Medicare & Medicaid Services (CMS), have processed and paid claims submitted by physicians, clinical laboratories, suppliers, and ASCs. Medicare Part A fiscal intermediaries, also under contract with CMS, have processed and paid claims submitted by hospital outpatient departments. Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 required CMS to transfer the functions of carriers and fiscal intermediaries to Medicare administrative contractors (MAC) between October 2005 and October 2011. Many, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the carrier, fiscal intermediary, or MAC, whichever is applicable.

As authorized by the Health Insurance Portability and Accountability Act of 1996, CMS contracts with program safeguard contractors to perform Medicare program integrity activities.[1] Under CMS's Umbrella Statement of Work, these contractors conduct medical reviews, cost report audits, data analyses, provider education, and fraud detection and prevention.

Prior Office of Inspector General Reports

Our previous reviews found that several Medicare contractors overpaid physicians who did not correctly identify the place of service on their billings. (See Appendix A.) Our recommendations in those reports called for the Medicare contractors to educate physicians regarding proper billing, recover identified overpayments, and analyze postpayment data to detect and recover overpayments for improperly billed claims. The Medicare contractors and CMS generally concurred with our recommendations.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether physicians correctly coded nonfacility places of service on selected Part B claims submitted to and paid by Medicare contractors.

Scope

Our nationwide audit covered 484,218 nonfacility-coded physician services valued at $42,385,710 that were provided during calendar year 2007 and that matched hospital outpatient or ASC claims for the same type of service provided to the same beneficiary on the same day.

The objective of our audit did not require an understanding or assessment of the complete internal control structure at the nonfacility locations or the Medicare contractors. Therefore, we limited our review of internal controls at nonfacility locations to obtaining an understanding of controls related to developing and submitting Medicare claims. We limited our review of internal controls at the Medicare contractors to the payment controls in place to prevent overpayments resulting from place-of-service billing errors.

We conducted our fieldwork from August through October 2009.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- reviewed the calendar year 2007 physician fee schedule to identify the types of physician services that had varying payment levels depending on the place of service;

[1] CMS is replacing program safeguard contractors with zone program integrity contractors.

- used data from the National Claims History file to match physician claims for services with varying payment levels that were coded as having been performed in nonfacility locations to claims from hospital outpatient departments or ASCs for the same service provided to the same beneficiary on the same date and identified 484,218 physician services;

- selected a stratified random sample of 100 paid services, stratified by the type of corresponding facility claim (i.e., hospital outpatient or ASC), from the sampling frame of services that were potentially billed with incorrect place-of-service codes (Appendix B);

- reviewed paid claim data from the Common Working File for each sampled service to validate the payment amount and to determine the place of service identified on the claim;

- sent detailed internal control questionnaires and requests for medical and billing records to, and received responses from, the 97 physicians who provided the 100 sampled services;

- reviewed questionnaire responses and medical and billing records and, if necessary, followed up with physicians or their billing agents to request additional information to confirm the correct place of service, identify coding discrepancies, and identify the causes of incorrect coding;

- followed up with hospital outpatient departments and ASCs, when necessary, to verify that the sampled services were performed at the facilities;

- calculated any Medicare overpayments for the sampled services;

- reviewed Common Working File data to determine whether claims for the sampled services had subsequently been adjusted;

- estimated the total value of overpayments in the sampling frame (Appendix C); and

- discussed the results of our review with Medicare contractor officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Physicians did not always correctly code nonfacility places of service on Part B claims submitted to and paid by Medicare contractors. Physicians correctly coded the claims for 10 of the 100 services that we sampled. However, physicians incorrectly coded the claims for 90 sampled services by using nonfacility place-of-service codes for services that were actually performed in hospital outpatient departments or ASCs. The incorrect coding resulted in overpayments totaling $4,710.

Based on these sample results, we estimated that Medicare contractors nationwide overpaid physicians $13.8 million for incorrectly coded services provided during calendar year 2007. We attribute the overpayments to internal control weaknesses at the physician billing level and to insufficient postpayment reviews at the Medicare contractor level to identify potential place-of-service coding errors.

PAYMENTS BASED ON INCORRECT PLACE OF SERVICE

Medicare Requirements

Medicare payments for physician services are based on the lower of the actual charge or the physician fee schedule amount.[2]

For a physician to receive the higher nonfacility practice expense payment for a service, the service must meet the requirements of 42 CFR § 414.22(b)(5)(i)(B). During our audit period,[3] this rule provided: "The higher nonfacility practice expense RVUs [relative value units] apply to services performed in a physician's office, a patient's home, an ASC if the physician is performing a procedure not on the ASC approved procedures list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure." CMS publishes a physician fee schedule in the *Federal Register* showing those services that have a higher payment rate if they are performed in nonfacility locations.

Results of Sample

Physicians incorrectly coded the place of service for 90 of the 100 sampled services.[4] Although all 90 services were coded as having been performed in a nonfacility location, 60 of the services

[2] Section 1848(a)(1) of the Social Security Act, 42 U.S.C. § 1395w-4 (a)(1).

[3] Effective January 1, 2008, CMS revised 42 CFR § 414.22(b)(5)(i)(A) and (B) to provide that the higher facility practice expense payment will no longer be made to physicians for procedures that are performed in an ASC but are not on the ASC-approved procedures list.

[4] For 10 sampled services, physicians correctly coded their offices as the place of service. Our match identified these services as potentially miscoded because they were for beneficiaries who had two evaluation and management procedures performed on the same day, one by a physician in the physician's office and the other by a different practitioner in a hospital outpatient department.

were actually performed in hospital outpatient departments and 30 were ASC-approved procedures performed in ASCs.

Of the 90 incorrectly coded services, 1 did not result in an overpayment because the physician's billing did not exceed the Medicare fee schedule amount for the correct facility setting. For each of the 89 remaining services, the physician's actual charge exceeded the Medicare fee schedule amount associated with the facility place-of-service code. Therefore, when those services were billed with the nonfacility place-of-service code, the Medicare contractors incorrectly reimbursed the physicians for the overhead portion of their services.

Example of Incorrect Coding

A carrier paid a physician $374 for performing a spinal pain injection procedure coded as having been performed in his office. Our analysis showed that the physician actually performed this procedure in a hospital outpatient department and that a fiscal intermediary had reimbursed the hospital for the overhead portion of the service. If the claim had been coded correctly, the physician would have received a payment of $96, which would not have included overhead costs. As a result of the incorrect coding, the physician was overpaid $278.

By repricing claims using the correct place-of-service code, we determined that Medicare contractors overpaid physicians $4,710 for the 90 services that physicians had billed incorrectly.

Estimate of Overpayments

Based on these sample results, we estimated that Medicare contractors nationwide overpaid physicians $13,766,568 for services provided in calendar year 2007 that were billed using incorrect place-of-service codes. (See Appendix C.)

Internal Control Weaknesses and Insufficient Postpayment Reviews

Many physicians had not implemented internal controls to prevent billings with incorrect place-of-service codes. Physicians and their billing personnel or billing agents told us that they had coded the place of service incorrectly for one or more of the following reasons:

- Physicians' billing personnel or billing agents were confused about the precise definition of a "physician's office" or other nonfacility location or were simply following established practice in applying the nonfacility codes.

- Physicians' billing agents were unaware that an incorrect place-of-service code could change the Medicare payment for a specific service.

- Personnel made isolated data entry errors.

- Undetected flaws in the design or implementation of some billing systems caused all claims to be submitted with a nonfacility location as the place of service.

Physicians and their staff used the nonfacility place-of-service codes even though they knew, or should have known, that the service was performed in a facility location. Medicare claim form instructions specifically state that each provider or practitioner who submits claims to Medicare is responsible for becoming familiar with Medicare coverage and billing requirements.

In addition, Medicare contractors and program safeguard contractors had not established sufficient postpayment reviews through coordinated data matches of Part A and Part B payments to identify potential place-of-service coding errors.[5]

RECOMMENDATIONS

We recommend that CMS instruct its Medicare contractors to:

- recover the $4,710 in overpayments for the sampled services;

- immediately reopen the claims associated with the 484,118 nonsampled services, review our information on these claims (which have estimated overpayments of $13,761,858), and work with the physicians who provided the services to recover any overpayments;

- continue to strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes; and

- continue to work with program safeguard contractors and, if necessary to coordinate Part A and Part B data matches, with other Medicare contractors to (1) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. CMS requested that we provide the data necessary to recover overpayments for the sampled and nonsampled services. With respect to the nonsampled services, CMS stated that it would review the most appropriate claims based on the cost-effectiveness of the review. CMS's comments are included in their entirety as Appendix D.

We will provide CMS with the requested data.

[5] Our prior place-of-service audits found that some program safeguard contractors, in coordination with Medicare contractors, performed limited postpayment reviews.

APPENDIXES

APPENDIX A: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number	Issue Date
Review of Payments Made by National Heritage Insurance Company for Ambulatory Surgical Procedures for Calendar Year 2001 (A-01-02-00524)	July 23, 2003
Review of Place of Service Coding for Physician Services - Wisconsin Physician Services, Madison, Wisconsin (A-05-04-00025)	October 7, 2004
Review of Place of Service Coding for Physician Services - Trailblazer Health Enterprises, LLC, for the Period January 1, 2001, Through December 31, 2002 (A-06-04-00046)	January 21, 2005
Review of Place of Service Coding for Physician Services (A-02-04-01010)	January 26, 2005
Review of Place of Service Coding for Physician Services Processed by National Heritage Insurance Company During Calendar Years 2002 and 2003 (A-01-06-00502)	December 7, 2006
Review of Place-of-Service Coding for Physician Services Processed by First Coast Service Options, Inc., During Calendar Years 2004 and 2005 (A-01-07-00518)	July 8, 2008
Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Years 2005 and 2006 (A-01-08-00528)	June 17, 2009

APPENDIX B: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

The sampling frame was a database of 484,218 nonfacility-coded physician services for calendar year 2007 that matched hospital outpatient or ambulatory surgical center (ASC) claims for the same service provided to the same beneficiary on the same day. We stratified the sampling frame into two strata. The first stratum consisted of 444,277 physician services that matched hospital outpatient claims, and the second stratum consisted of 39,941 physician services that matched ASC claims.

SAMPLE UNIT

The sample unit was a nonfacility-coded line item of service billed by a physician that matched a line item of service billed by a hospital outpatient department or an ASC.

SAMPLE DESIGN

We used a stratified random sample. Stratum 1 consisted of physician line items of service that matched hospital outpatient line items of service, and stratum 2 consisted of physician line items of service that matched ASC line items of service.

SAMPLE SIZE

We selected 100 matched line items of service: 70 from stratum 1 and 30 from stratum 2.

SOURCE OF THE RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services, statistical software to generate the random numbers.

METHOD OF SELECTING SAMPLED ITEMS

We consecutively numbered the sample units in the frame from 1 to 444,277 in stratum 1 and from 1 to 39,941 in stratum 2. After generating 70 random numbers for stratum 1 and 30 for stratum 2, we selected the corresponding sample units.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the overpayments.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Frame Value	Sample Size	Sample Value	Number of Overpayments	Value of Overpayments
1 – Hospital outpatient	444,277	$31,894,832	70	$4,912	60	$1,494
2 – ASC	39,941	10,490,878	30	7,190	30	3,216
Total	**484,218**	**$42,385,710**	**100**	**$12,102**	**90**	**$4,710**

Estimated Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$13,766,568
Lower limit	10,145,848
Upper limit	17,387,287

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 10 2010

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Tavenner
Acting Administrator and Chief Operating Officer

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Year 2007" (A-01-09-00503)

Thank you for the opportunity to review and comment on the Office of Inspector General's draft report, "Review of Place-of-Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Year 2007." The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources the OIG has invested to determine the extent to which physicians correctly coded nonfacility places of service on selected Part B claims submitted to and paid by Medicare.

Part B services are provided in facility settings (e.g., outpatient hospital departments and ambulatory surgical centers (ASCs), and in nonfacility settings (e.g., a physician's office, an urgent care center, an independent clinic, etc.). Medicare reimburses physicians at a higher rate for certain services performed in nonfacility locations to account for overhead expenses. A lower payment is made to the physician when the same procedures are provided in facility settings because the overhead costs are reimbursed to the facility separately.

During this audit, the OIG reviewed claims for approximately 100 services and concluded claims for Part B services were incorrectly coded for the place of service. The OIG's recommendations addressed recoupment of improper payments and strengthening education of physicians for place-of-service codes.

When problems with operational billing or coding policy are identified, CMS typically conducts additional education, both nationally and through its FFS contractors, to remind providers of proper procedures. In addition, once claims have been paid, CMS employs several strategies to ensure the accuracy of payment. CMS coordinates the development of contractor medical review policy and processes to ensure both automated and complex medical reviews are done accurately. Medicare Administrative Contractors (MACs) conduct data analysis and adjust their individual medical review strategies based on identified problem areas. As described in our

detailed responses, CMS is currently exploring a pilot project which includes post-payment review for a portion of the nonsampled claims.

The CMS looks forward to continually working with OIG on issues related to waste, fraud and abuse in the Medicare program.

The OIG made the following recommendations:

OIG Recommendation 1

Recover the $4,710 in overpayments for the sampled services.

CMS Response

The CMS concurs. The CMS will recover the $4,710 in overpayments consistent with the Agency's policies and procedures. The CMS requests that the OIG provide the data necessary (i.e. provider numbers, claim information including the paid date, HIC numbers, etc.) to assist the Medicare contractors in identifying the claims in question. We also ask that Medicare contractor-specific data be written to separate compact disks in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation 2

Immediately reopen the claims associated with the 484,118 nonsampled services, review our information on these claims (which have estimated overpayments of $13,761,858) and work with the physicians who provided the services to recover any overpayments.

CMS Response

The CMS concurs with comments. CMS will review the most appropriate claims based on the cost effectiveness of review. OIG has estimated an overpayment of approximately $28 a claim. Based on the findings in the June 17, 2009 OIG report, "Review of Place of Service Coding for Physician Services Processed by Medicare Part B Carriers During Calendar Years 2005 and 2006," CMS is currently exploring a pilot project to review nonsampled claims. Based on recent conversations with the OIG, a strategy has been developed to handle these claims. Pending funds availability, CMS will send the ASC claims to the appropriate MACs for automated review. The CMS will also consider reviewing a portion of the outpatient claims.

The CMS must always consider return on investment when conducting medical review due to the limited resources associated with medical review activities. The CMS attempts to focus its medical review resources on the most highly vulnerable areas as identified by the Comprehensive Error Rate Testing (CERT) program and the individual contractors' data analysis.

OIG Recommendation 3

Continue to strengthen their education process and reemphasize to physicians and their billing agents the importance of correctly coding the place of service and the need for internal controls to prevent Medicare billings with incorrect place-of-service codes.

CMS Response

The CMS concurs. CMS will again communicate the proper place-of-service coding policy to contractors and physicians through the issuance of a Medicare Learning Network (MLN) article. CMS will also hold an open door forum call with the provider community to reemphasize the importance of proper coding for place-of-service on claims.

OIG Recommendation 4

Continue to work with program safeguard contractors and, if necessary to coordinate Part A and Part B data matches, with other Medicare contractors to (1) develop a data match that will identify physician services at high risk for place-of-service miscoding and (2) recover any identified overpayments.

CMS Response

The CMS concurs. We agree that the program safeguard contractors and other Medicare contractors should continue to coordinate their efforts in this area.

Attachment

ATTACHMENT

The CMS requests that OIG send the data in the following format for Recommendation 2. For each contractor ID, a separate CD with their outpatient and ASC claims on separate worksheet tabs. The data fields should include all financial, provider and beneficiary fields necessary for a complex medical review. Please include the name of the study, date ranges of the data and other parameters on each CD. This documentation summary could be printed on the CD cover or added as an additional worksheet. The title of each CD should also include the contractor Name/ID(s). The overpayment data referred to in Recommendation 1 should be sent on discs separate from the nonsampled claims data referred to in Recommendation 2.

The CMS also requests two master files be prepared with all contractor data to be accessed through the HHS/OIG delivery server. The first master file should include ASC data and the second should include outpatient data. The data should include a contractor ID and contractor name field. With this data, the CMS can create a pivot table to determine the rank of the contractors based on their overpayment of paid dollar amounts.