DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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SUBJECT: Memorandum Report: *Payments for Medicare Part B Services During Non-Part A Nursing Home Stays in 2008*, OEI-06-07-00580

This memorandum report provides information regarding the extent to which Medicare paid for Part B services during non-Part A[1] nursing home[2] stays (hereinafter referred to as non-Part A stays) in 2008. We used resident assessment data from the Minimum Data Set (MDS) to identify all nursing home stays nationwide during 2008 and reviewed Part B claims that occurred during non-Part A stays.

SUMMARY

This study is part of the Office of Inspector General's (OIG) activities to address section 313(d) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA).[3] BIPA required the Secretary of Health & Human Services, through OIG, to monitor Part B payments for items and services furnished to nursing home residents during stays not covered by Part A to guard against excessive services. To facilitate identification of areas where such vulnerability may occur, this study provides an overview of Part B services that occurred during non-Part A stays. Insights into payment and utilization patterns, as well as geographic differences, may suggest possible areas for further review by OIG and the Centers for Medicare & Medicaid Services (CMS).

[1] Nursing home stays not paid for by Part A constitute non-Part A stays. Part A covers posthospital skilled nursing facility (SNF) care to eligible beneficiaries for up to 100 days in SNFs, during which Part A will pay for most services as part of the nursing home's daily rate. After the 100 days or if the beneficiary does not qualify for a Part A stay, Part B may provide coverage for some services.

[2] For purposes of this evaluation, the term "nursing home" refers to any nursing home regardless of primary payer (e.g., Medicare, Medicaid, or private resources).

[3] P.L. 106-554.

We found that Medicare paid $4.9 billion for Part B services during non-Part A stays in 2008. Three service categories, therapy services, evaluation and management, and major and minor medical procedures, made up 58 percent of the total payment. In addition, Part B services were rendered in a variety of places, with 54 percent of payments for services rendered inside nursing homes and 46 percent of payments for services rendered outside of nursing homes (e.g., outpatient hospitals and physician offices).

On average, Medicare paid $16.75 per day per beneficiary for Part B services across all service categories and all beneficiaries. However, the average varied widely across service categories and States in which the services occurred; the highest average daily payments were for dialysis services and services in Louisiana. Examining average daily payments across nursing homes, we found that payments to some nursing homes exceeded three times the national average daily payment within certain service categories, most prominently drugs and biologicals and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

The variation and unusual patterns found in this review raise concerns of potential fraud, waste, and abuse. Therefore, items and services billed under Part B for nursing home residents during non-Part A stays continue to warrant specialized monitoring. To facilitate such monitoring, we plan to undertake additional reviews and in-depth analyses focusing on specific service types.

BACKGROUND

The BIPA requirement for special monitoring reflects vulnerabilities with Medicare payments for Part B services during non-Part A stays that generally do not exist for the same services provided during Part A stays. During a Part A stay, Medicare requires consolidated billing: nursing homes must arrange for and submit all Medicare claims for the services that their residents receive,[4] including services and supplies delivered by providers other than the nursing home.[5] For example, if a Medicare beneficiary receives a wheelchair and oxygen tanks from different suppliers following a hospital stay, Medicare requires the nursing home to collect, consolidate, and submit bills for payment under Part A. Once paid by Medicare, the nursing home is responsible for reimbursing the suppliers their portion of the payment. Consolidated billing ensures that the nursing home is aware of services provided to its residents, which helps it to coordinate care for beneficiaries and to safeguard against excessive services by providers.

When Part A does not cover a Medicare beneficiary's nursing home stay (a non-Part A stay), individual providers, rather than the nursing home, may bill Medicare directly for Part B services,

[4] Social Security Act, §§ 1862(a)(18) and 1842(b)(6)(E).

[5] Pursuant to Section 1888(e)(2)(A)(ii) and (iii) of the Social Security Act, services excluded from consolidated billing requirements during Part A covered SNF stays include physicians' professional services, certain dialysis-related services, certain drugs, and certain ambulance services. Section 1888(e)(2)(A)(ii) of the Social Security Act specifies that physical therapy, occupational therapy, and speech-language pathology services for SNF residents are always subject to consolidated billing requirements regardless of whether they are furnished by (or under the supervision of) a physician or other health care professional. A full listing of excluded services may be accessed at https://www.cms.gov/SNFPPS/05_ConsolidatedBilling.asp.

creating particular vulnerabilities for program integrity. For example, although nursing homes are likely aware of the services provided to their residents, they may never see the claims submitted to Medicare by outside providers and therefore not have an opportunity to verify the accuracy of claims.

Related Work

Several recent OIG reports found improper payments and other vulnerabilities for Part B services that occurred during non-Part A stays. For example, one report found improper payments of $30 million made by Part B for durable medical equipment during non-Part A stays in 2006.[6] Suppliers incorrectly listed these items for use in beneficiaries' homes when usage actually occurred in the nursing home, a place of service not covered by Part B unless the nursing home qualifies as the beneficiary's home. Because these nursing homes were providing primarily skilled care or rehabilitation, they could not be considered the beneficiaries' homes. Additionally, OIG found problems related to coding, medical necessity, and maintaining adequate documentation for enteral nutrition therapy services[7] and mental health services,[8] resulting in $39 million and $74 million, respectively, in improper payments during 2006.

METHODOLOGY

Scope

We identified Medicare payments for, and beneficiaries' utilization of, Part B services during non-Part A stays in 2008. We did not examine (1) any Part B service that occurred during a Part A covered stay or (2) the medical appropriateness of any Part B service.

Identification of Part B Services During Non-Part A Stays

We utilized several databases obtained from CMS to identify Part B payments for services during non-Part A stays. These databases included the MDS; the Online Survey, Certification, and Reporting System; the Enrollment Database; and the National Claims History. (See Appendix A for a detailed description of the databases and the methods used to identify Part B services during non-Part A stays in 2008.)

Service Categorization

To facilitate analysis of all services paid for by Part B during non-Part A stays, we developed a comprehensive categorization of services by modeling service categories after the American Medical Association's Current Procedural Terminology code delineations and the Berenson-Eggers Type of Service system. (See Appendix B for further details regarding the creation and structure of the categorization.) This categorization organized the more than 14,000 Healthcare Common Procedure Coding System (HCPCS) codes using a structure that resulted in 14 broad service categories. The categorization also included a category of "other" services that we were unable to

[6] OIG, *Part B Services During Non-Part A Nursing Home Stays: Durable Medical Equipment* (OEI-06-07-00100), July 2009.

[7] OIG, *Medicare Part B Services During Non-Part A Nursing Home Stays: Enteral Nutrition Therapy* (OEI-06-07-00090), June 2010.

[8] OIG, *Medicare Part B Services During Non-Part A Nursing Home Stays: Mental Health* (OEI-06-06-00580), July 2010.

classify into a particular category. We further divided these 14 categories into subcategories to provide more specificity when analyzing services within categories.

Analysis of Payments and Utilization
We reviewed 8,195 unique HCPCS codes representing the Part B services paid for during non-Part A stays in 2008. After categorizing these codes, we conducted several types of analyses to provide an overview of payments and utilization.

Payment analysis. We calculated the following summary statistics for each of the 14 service categories: total Part B payments, percentage of total Part B payments, number of beneficiaries who received a service in the category, percentage of total beneficiaries who received a service in the category, and average Part B payments per beneficiary. For many of the highest dollar service categories, we also identified the subcategories in which the majority of payments were made. In addition, we examined Part B payments across places of service for each of the 14 service categories.

States' payment patterns. To identify potential differences in States' payment patterns, we computed the payment percentage for each service category within a State. For example, if a State received $100 million in total Part B payments for services, and the category of evaluation and management accounted for $50 million, the payment percentage of the evaluation and management category was 50 percent. Therefore, summing the percentages across each of the 14 service categories yielded 100 percent within a State. After computing payment percentages for each State, we compared these rates against the national rate to identify States that had high payment rates.

Comparative payment analysis. By accounting for the duration of beneficiary nursing home stays, we computed a measure for comparing cost differences among service categories, States, nursing homes, and beneficiaries. This standardizing measure, the average daily payment, identifies the average that Medicare paid per day for services during a beneficiary's nursing home stay. For example, a beneficiary who receives $1,000 in Part B services during a 100-day nursing home stay has an average daily payment of $10. To determine the national average across Part B services, we computed an average daily payment rate for each beneficiary within our review and then averaged these rates. To determine average daily payment across service categories, States, and nursing homes, we first sorted beneficiaries by these groupings and then calculated average daily payments among beneficiaries who received such services.

Standards
This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

RESULTS

Medicare Paid $4.9 Billion for Part B Services During Non-Part A Stays in 2008, With Three Service Categories Accounting for 58 Percent of the Total Payments

During non-Part A stays in 2008, Part B paid for a variety of services for 1.5 million beneficiaries who resided in 16,059 nursing homes. Of the 14 Part B categories we reviewed, therapy services, evaluation and management, and major and minor medical procedures together accounted for $2.8 billion—more than half of the $4.9 billion paid by Part B. Table 1 contains payment amounts and utilization statistics for each of the service categories. (See Appendix C for additional payment and utilization statistics for Part B services during non-Part A stays in 2008.)

Table 1: Payment and Utilization Statistics for 14 Part B Service Categories During Non-Part A Stays in 2008

Service Category	Part B Payment	Total Part B Percentage of Payment	Number of Beneficiaries Who Received These Services	Percentage of Beneficiaries Who Received These Services	Average Payment per Beneficiary
Therapy services	$1,314,988,128	27%	731,356	48%	$1,798
Evaluation and management	$1,049,333,598	21%	1,415,945	94%	$741
Major and minor medical procedures	$464,983,013	10%	1,290,463	85%	$360
Pathology and laboratory	$394,283,013	8%	1,286,796	85%	$306
Transportation services	$374,453,747	8%	339,282	22%	$1,104
Radiology and imaging	$286,748,086	6%	862,805	57%	$332
Dialysis services	$264,308,170	5%	31,254	2%	$8,457
Enteral and parenteral therapy	$224,110,762	5%	55,677	4%	$4,025
DMEPOS	$212,940,491	4%	374,099	25%	$569
Drugs and biologicals	$211,725,750	4%	420,721	28%	$503
Endoscopy	$45,997,999	1%	130,716	9%	$352
Oncology	$26,110,191	1%	12,614	1%	$2,070
Anesthesia	$10,271,963	<1%	62,789	4%	$164
Other	$381,402	<1%	2,958	<1%	$129
Total	**$4,880,636,313**	**100%***	**1,511,974****	**—**	**—**

Source: OIG analysis of paid Part B services during non-Part A stays in 2008.

* The column does not total to 100% because of rounding.

** The total number of unique nursing home Medicare residents who received any Part B service during non-Part A stays in 2008.

Therapy services, the highest paid service category with $1.3 billion, accounted for 27 percent of the total Part B payment. Forty-eight percent of beneficiaries utilized at least one therapy service. The category of therapy services includes physical therapy, occupational therapy, speech-language pathology services, hydration and prophylactic therapy, alternative therapies (e.g., acupuncture), and other forms of physical medicine and rehabilitation. Of these subcategories, physical therapy, occupational therapy, and speech-language pathology services accounted for 99 percent ($1.3 billion) of the Part B payment for the therapy services category. Additionally, therapeutic exercise, the highest paid individual HCPCS code within the therapy services category, was also the highest paid HCPCS code among all Part B services, with $383 million in total payment.

Evaluation and management, the second-highest paid category with $1 billion, accounted for 21 percent of the total Part B payment. Nearly all beneficiaries—94 percent—utilized at least one service in this category. The evaluation and management category encompasses services such as medical visits (e.g., nursing home, emergency, office or other outpatient, hospital, and home visits), psychiatry and alcohol/drug treatment, consultations, special evaluation and management, and preventive medicine. Of these subcategories, nursing home visits accounted for 57 percent ($593 million) of the evaluation and management category payment. Additionally, four HCPCS codes (99307–99310), corresponding to a group of services encompassing visits lasting between 10 and 35 minutes called subsequent nursing home care, accounted for 53 percent ($553 million) of the amount paid for this category.

Major and minor medical procedures, the third-highest paid category with $465 million, accounted for 10 percent of the total Part B payment. Eighty-five percent of beneficiaries utilized at least one service in this category. The category of major and minor medical procedures consists of surgical and other medical procedures grouped according to body systems, such as the cardiovascular, integumentary (e.g., skin), vision and hearing, musculoskeletal, and nervous systems. The vast majority of these services involve complex and skilled procedures to repair damaged body parts, remove malignancies, or treat dysfunctions. Of the body systems, cardiovascular ($168 million), integumentary ($126 million), and vision and hearing ($89 million) together accounted for 83 percent of major and minor medical procedures. Furthermore, services generally provided by podiatrists represent 21 percent ($96 million) of the amount paid for services in this category.

Three Places of Service Comprised 76 Percent of the Total Payment Made by Part B During Non-Part A Stays in 2008

Nursing homes, outpatient hospitals, and end-stage renal disease (ESRD) treatment facilities together made up $3.7 billion, or 76 percent of the $4.9 billion paid by Part B (see Table 2). Nursing homes, the places of service associated with the highest overall payment, accounted for 54 percent ($2.6 billion) of the total Part B payment. Outside of nursing homes, several places of service together accounted for the remaining 46 percent ($2.3 billion) of the total payment made by Part B during non-Part A stays in 2008.

Table 2: Payments Across Places of Service for Part B Services During Non-Part A Stays in 2008

Place of Service	Part B Payment	Total Part B Percentage of Payment
Nursing home	$2,631,865,410	54%
Outpatient hospital	$630,212,887	13%
ESRD facility	$451,148,936	9%
Ambulance	$360,129,994	7%
Physician office	$294,137,372	6%
Other*	$310,896,613	6%
Independent laboratory	$202,245,101	4%
Total	**$4,880,636,313**	**100%****

Source: OIG analysis of paid Part B services during non-Part A stays in 2008.

* Other included a variety of settings, such as the home, ambulatory surgical centers, emergency rooms, custodial care facilities, mobile units, intermediate care facilities, assisted living facilities, community mental health centers, and home health agencies.

** The column does not total to 100% because of rounding.

Certain service categories were primarily associated with a nursing home place of service, whereas others were primarily associated with places of service outside of a nursing home. Most payments for the categories of enteral and parenteral therapy (98 percent), therapy services (97 percent), and evaluation and management (67 percent) were for services rendered within nursing homes (see Table 3). Conversely, most payments for the following service categories were for services rendered outside of nursing homes: major and minor medical procedures (72 percent), pathology and laboratory (92 percent), transportation services (99 percent), dialysis services (99 percent), drugs and biologicals (95 percent), endoscopy (95 percent), oncology (99 percent), and anesthesia (99 percent). Payments for the remaining service categories, radiology and imaging and DMEPOS, were nearly evenly distributed between the nursing home and places outside of the nursing home. (See Appendix D for payment statistics across Part B service categories for all places of services during non-Part A stays in 2008.)

Table 3: Payment (in Millions) Across Places of Service for 14 Part B Service Categories During Non-Part A Stays in 2008

Service Category	Within Nursing Homes		Outside of Nursing Homes		Total
	Part B Payment	Percentage of Payment Within Service Category	Part B Payment	Percentage of Payment Within Service Category	Part B Payment
Therapy services	$1,271	97%	$44	3%	$1,315
Evaluation and management	$704	67%	$345	33%	$1,049
Major and minor medical procedures	$130	28%	$335	72%	$465
Pathology and laboratory	$32	8%	$362	92%	$394
Transportation services	<$1	<1%	$374	>99%	$374
Radiology and imaging	$149	52%	$138	48%	$287
Dialysis services	<$1	<1%	$264	>99%	$264
Enteral and parenteral therapy	$220	98%	$4	2%	$224
DMEPOS	$114	53%	$99	47%	$213
Drugs and biologicals	$11	5%	$201	95%	$212
Endoscopy	$2	5%	$44	95%	$46
Oncology	<$1	<1%	$26	>99%	$26
Anesthesia	<$1	<1%	$10	>99%	$10
Other	<$1	5%	<$1	95%	<$1
Total*	**$2,632**	**54%**	**$2,249**	**46%**	**$4,881**

Source: OIG analysis of paid Part B services during non-Part A stays in 2008.

* These totals represent the aggregate across all service categories.

Some States Had Much Higher Payment Rates Than the National Rate for Certain Part B Service Categories

The following States exhibited much higher payment rates: Tennessee, Minnesota, Nevada, California, Arkansas, the District of Columbia, South Carolina, Alaska, and North Dakota (see

Table 4).[9] For example, payments for the category of enteral and parenteral therapy in Tennessee totaled 20 percent of Tennessee's total Part B payment, which is 4.4 times higher than the national rate of 4.6 percent. Possible explanations for geographic differences may include differences in fraud, waste, and abuse or differences in the levels of patient wellness (i.e., the degree to which patients' care needs are defined).

Table 4: States With Higher Payment Rates Than the National Rate Across Part B Service Categories During Non-Part A Nursing Home Stays in 2008

State	Service Category	Service Payment	Total Part B Payment	State Payment Rate	National Payment Rate	State to National Percentage Ratio
Tennessee	Enteral & parenteral therapy	$28,407,009	$139,698,220	20.3%	4.6%	4.4 : 1
Minnesota	Enteral & parenteral therapy	$10,039,756	$50,272,634	20.0%	4.6%	4.3 : 1
Nevada	DMEPOS	$2,153,130	$13,745,084	15.7%	4.4%	3.6 : 1
California	DMEPOS	$59,510,343	$407,222,450	14.6%	4.4%	3.3 : 1
Arkansas	DMEPOS	$7,636,268	$58,557,303	13.0%	4.4%	3.0 : 1
District of Columbia	Dialysis services	$1,111,627	$7,159,009	15.5%	5.4%	2.9 : 1
South Carolina	Transportation services	$12,563,748	$58,910,790	21.3%	7.7%	2.8 : 1
Alaska	Dialysis services	$246,590	$1,629,854	15.1%	5.4%	2.8 : 1
Alaska	Pathology & laboratory	$352,567	$1,629,854	21.6%	8.1%	2.7 : 1
North Dakota	Drugs & biologicals	$1,628,904	$14,208,702	11.5%	4.3%	2.7: 1

Source: OIG analysis of paid Part B services during non-Part A stays in 2008.

On Average, Medicare Paid $16.75 per Day for Beneficiaries' Part B Services During Non-Part A Stays in 2008

Aggregating across all Part B services paid for and averaging across all beneficiaries during non-Part A stays in 2008, we found that the average daily payment was $16.75 (see Table 5 on page 9). This figure served as a reference point when comparing service categories and States.

Aggregating across service categories, dialysis services exhibited the highest average daily payment of $49.74 during non-Part A stays in 2008. Two factors influenced the average daily payment of any given service category: relative cost per beneficiary (or "expensiveness" of the service category) and the duration of beneficiaries' nursing home stays. The category of dialysis services was the most expensive at $8,457 per beneficiary (see Table 1 on page 5). Further, beneficiaries who received a service in this category exhibited short nursing home stays compared to beneficiaries who received other services, potentially because of their low survival rate (the measure of how long patients live after initial diagnosis).[10] We attribute this to the chronic nature

[9] Although Puerto Rico and the U.S. Virgin Islands exhibited unusual payment patterns for certain Part B service categories, we did not include them in the analysis because payments for services in each territory totaled less than $50,000.

[10] As indicated in a 2007 study by the U.S. Renal Data System, the 90-day survival rates of dialysis patients are 92.1, 88.5, 83.6, and 79 percent for patients ages 65–69, 70–79, 80–84, and over 85, respectively. However, these survival rates drop significantly by the end of the first year of dialysis to 79.4, 72.5, 63.9, and 57.5 percent for the same age groups. U.S. Renal Data System, *USRDS 2010 Annual Data Report: Atlas of Chronic Kidney Disease and End-Stage Renal Disease in the United States*, National Institutes of Health, National Institute of Diabetes and Digestive and Kidney Diseases. Accessed at http://www.usrds.org on May 23, 2011.

of ESRD, which requires frequent, expensive dialysis treatments (e.g., three times a week for 3 hours or more per visit) or a kidney transplant.[11]

Table 5: Average Daily Payment Across 14 Part B Service Categories During Non-Part A Nursing Home Stays in 2008

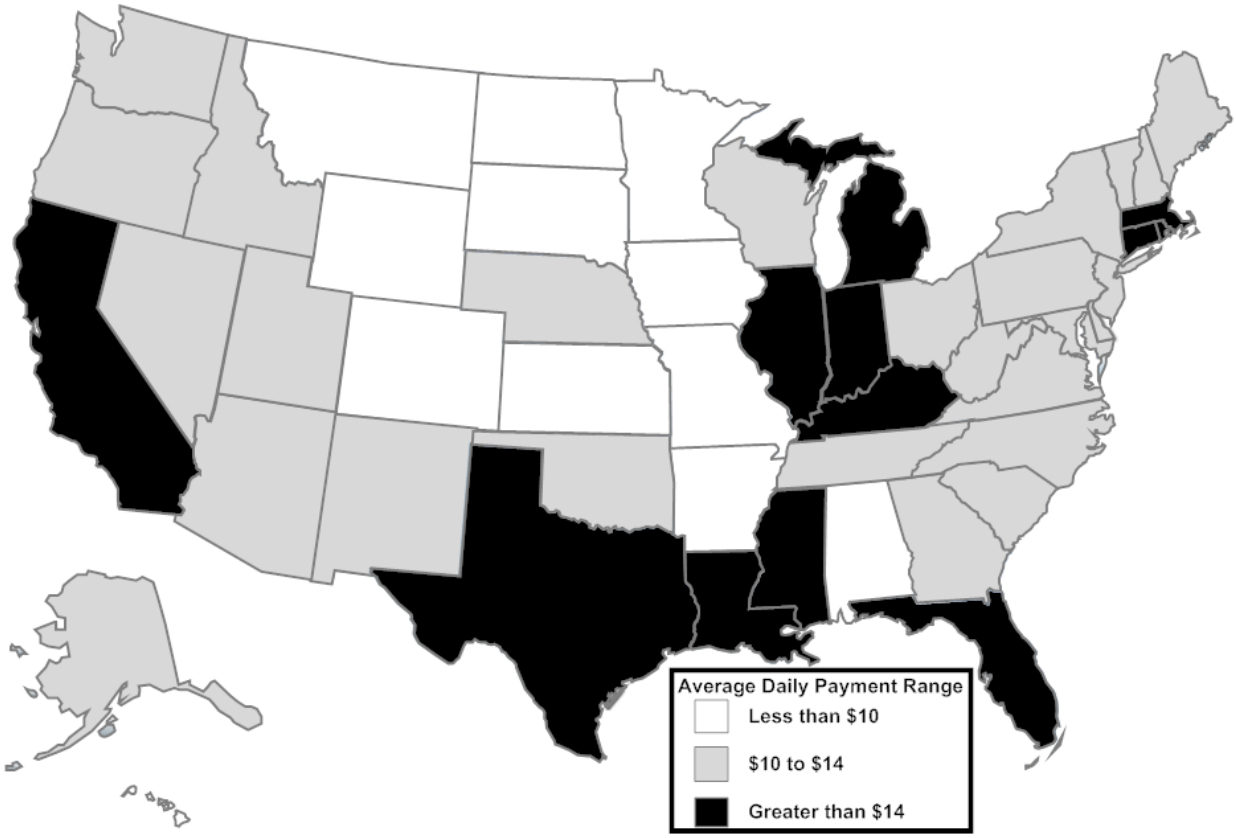
	Average Daily Payment
Across All Part B Services	**$16.75**
Service Category	
Dialysis services	$49.74
Oncology	$20.77
Enteral and parenteral therapy	$16.42
Therapy services	$11.25
Transportation services	$8.71
Evaluation and management	$3.91
DMEPOS	$3.39
Drugs and biologicals	$3.27
Endoscopy	$2.50
Radiology and imaging	$2.04
Major and minor medical procedures	$1.77
Pathology and laboratory	$1.52
Anesthesia	$1.25
Other	$1.06

Source: OIG analysis of paid Part B services during non-Part A stays in 2008.

Aggregating across States, Louisiana exhibited the highest average daily payment of $19.13 during non-Part A stays in 2008. Many of the States located along the Gulf of Mexico and the Midwest exhibited relatively high average daily payments (see Figure 1). Conversely, States located in the north-central part of the country exhibited relatively low average daily payments.

[11] National Institute of Diabetes and Digestive and Kidney Diseases, *Treatment Methods for Kidney Failure: Hemodialysis*, December 2006. Accessed at http://kidney.niddk.nih.gov/kudiseases/pubs/hemodialysis/ on May 23, 2011.

Figure 1: Average Daily Payment By States for Medicare Beneficiaries' Part B Services During Non-Part A Nursing Home Stays in 2008*



Source: OIG analysis of paid Part B services during non-Part A stays in 2008.
*Not depicted are the District of Columbia, the U.S. Virgin Islands, and Puerto Rico, which exhibited $10.22, $6.60, and $9.12 in average daily payments, respectively.

Drugs and biologicals appeared the category most vulnerable to high average daily payments among nursing homes; however, DMEPOS may be of greater concern. On average, Medicare paid $3.27 per day during non-Part A stays in 2008 for the category of drugs and biologicals (see Table 5 on page 9). However, of the nursing homes associated with paid for drugs and biologicals services, 14 percent (1,247) exhibited an average daily payment greater than $9.81, which is triple the national average (see Table 6). There may be reasonable explanations for such high average daily payments. For example, one nursing home had an average daily payment of $37.49; yet, upon further review, we found that the nursing home operated an onsite dialysis unit and ESRD drugs drove the average daily payment. Such nursing home specializations may explain high billing in a particular service type.

The 3 percent of nursing homes with average daily payments higher than triple the national average for DMEPOS may be of greater concern. Nursing homes may exhibit high average daily payments because of a specialization unit, such as an onsite dialysis unit, but explanations are limited for extremely high average daily payments for DMEPOS. For example, at one nursing

home with an average daily payment of $40, there were 23 beneficiaries who received DMEPOS. Of those, nine had average daily payments ranging from $34 to $160—higher than the national average of $3.39. Such high average daily payments lend themselves to concerns of potential fraud, waste, and abuse.

Table 6: Percentage of Nursing Homes That Exceeded Triple the National Average Daily Payment Across 14 Part B Service Categories

Categories	National Average Daily Payment	Triple the National Average Daily Payment	Nursing Homes That Exceeded Triple the National Average Daily Payment	
			Percentage of Nursing Homes	Maximum Average Daily Payment
Across All Part B Services*	**$16.75**	**$50.25**	**<1%**	**$76**
Service Category * **				
Drugs and biologicals	$3.27	$9.81	14%	$71
DMEPOS	$3.39	$10.17	3%	$45
Endoscopy	$2.49	$7.47	2%	$22
Transportation services	$8.71	$26.13	2%	$76
Major and minor medical procedures	$1.77	$5.30	1%	$37
Therapy services	$11.25	$33.75	<1%	$59
Evaluation and management	$3.91	$11.72	<1%	$47
Pathology and laboratory	$1.52	$4.56	<1%	$14
Radiology and imaging	$2.04	$6.12	<1%	$11
Anesthesia	$1.25	$3.76	<1%	$5
Oncology	$20.77	$62.31	None exceeded	$37
Dialysis services	$49.74	$149.21	None exceeded	$69
Enteral and parenteral therapy	$16.42	$49.27	None exceeded	$26
Other	$1.06	$3.18	None exceeded	$2

Source: OIG analysis of paid Part B services during non-Part A stays in 2008.

* To provide meaningful comparisons among nursing homes, we only analyzed data for those nursing homes with more than 50 beneficiaries who received Part B services.

** To provide meaningful comparisons between service categories, we only included beneficiaries who had a nursing home stay longer than 14 days and nursing homes that had at least 10 beneficiaries who received a service in the service category (e.g., nursing homes with at least 10 beneficiaries who received services in the category of drugs and biologicals).

CONCLUSION

Medicare made payments totaling nearly $5 billion for Part B services provided to nursing home residents during non-Part A stays in 2008. This analysis of utilization and payments provides an overview of the depth and breadth of the services billed to Part B. We found significant variation in payment and utilization among different Part B service categories, places of service, States, and nursing homes. We also found unusual payment and utilization patterns that greatly exceeded national norms. Such variation and unusual patterns raise concerns of potential fraud, waste, and abuse. Therefore, services billed under Part B for nursing home residents continue to warrant monitoring by OIG and CMS.

To facilitate such monitoring, we plan to undertake additional reviews and in-depth analyses focusing on specific service types. Utilizing stay dates from the MDS, our data matches not only

allow us to identify Part B services provided to beneficiaries, but also demographic information for the nursing homes, providers, and beneficiaries associated with the claims. Such demographic information will allow us to perform detailed reviews to detect nursing homes that exhibit questionable billing patterns and the providers who furnish services to the residents of these nursing homes. For example, identifying a nursing home with beneficiaries who exhibit unusually high average daily payment rates for services may also identify providers who are billing for unnecessary Part B services. A subsequent review of these providers' claims would distinguish between those who have reasonable explanations for questionable billing patterns and those who warrant further investigation.

Additionally, we encourage CMS's continued use of its wide range of program integrity resources (e.g., Medicare Administrative Contractors and Recovery Audit Contractors) to scrutinize provider and supplier billing associated with this vulnerable patient population.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number OEI-06-07-00580 in all correspondence.

APPENDIX A

Identification of Medicare Part B Services During Non-Part A Nursing Home Stays

To identify Part B services during non-Part A stays, we utilized information from four Medicare program databases.

Minimum Data Set. The Minimum Data Set (MDS) forms the foundation of the comprehensive assessment for all residents of long-term care facilities certified to participate in Medicare or Medicaid. It includes information about each resident's health, as well as admission and discharge dates. We used the MDS (version 2.0) to identify all nursing home residents in 2008 and their Social Security numbers (SSN), related nursing homes, and stay dates. To determine resident stay dates between January 1 and December 31, 2008, we extracted all nursing home admission and discharge dates for each resident. We used assessment dates as proxies for missing admission or discharge dates according to the following assumptions:

- *Missing admission date*. If the resident was in the nursing home on January 1, 2008 (determined from subsequent assessments that the nursing homes conducted), we used the date of the first assessment conducted in 2007 as the admission date.
- *Missing discharge date*. We defined the date of the last assessment conducted by nursing homes and received by OIG through March 2009 as the discharge date.

Online Survey, Certification, and Reporting System. The Online Survey, Certification, and Reporting System (OSCAR) database contains nursing home facility demographic information, as well as survey results from nursing home certification and complaint surveys. To obtain information about nursing homes (e.g., facility name, address, number of beds, and certification status), we linked the MDS facility identification numbers with the facility numbers maintained in OSCAR.

Enrollment Database. The Enrollment Database (EDB) includes beneficiary-level data (e.g., name, SSN, and Medicare Health Insurance Claim Number (HICN)). Using this database, we matched SSNs contained in the MDS file to SSNs in the EDB to identify Medicare beneficiaries and their associated HICNs. We excluded beneficiaries who had no matching SSN from further analysis.

National Claims History. We used the National Claims History (NCH), a data reporting system that includes both Part A and Part B claims, to identify all claims allowed by Part B during non-Part A stays. To identify claims associated with Medicare beneficiaries with nursing home stays (identified earlier), we first matched their HICNs to the claims data. To identify claims for services provided only during non-Part A stays, we then removed all claims for Part A paid skilled nursing facility (SNF) stays and inpatient hospital stays by matching the stay dates from the MDS to the SNF and inpatient hospital claims in the NCH. The resulting dataset comprised all Part B claims for which billing was allowed for beneficiaries during non-Part A stays in 2008.

APPENDIX B

Categorization of Medicare Part B Services

To facilitate analysis of all Part B services utilized by beneficiaries during non-Part A nursing home stays, we developed a comprehensive and systematic categorization of services. This categorization organized the more than 14,000 services and their related Healthcare Common Procedure Coding System (HCPCS) codes into 14 broad service categories. In addition, each category includes subcategories for further detailed analysis across service types. For example, the evaluation and management category includes subcategories of office visits, consultations, or alcohol/drug treatment. To develop the categorization, we adapted three coding systems used by the Centers for Medicare & Medicaid Services (CMS) for billing, payment, and analysis: Current Procedural Terminology (CPT), Berenson-Eggers Type of Service (BETOS) system, and HCPCS.

1. CPT codes are developed, maintained, and copyrighted by the American Medical Association (AMA) and are used to identify services and procedures provided by physicians and other health care professionals.
2. The BETOS coding system covers all HCPCS codes; CMS uses it to analyze the growth in Medicare expenditures.
3. HCPCS Level I numerical codes are identical to CPT codes and are used by CMS when services and procedures involve Medicare beneficiaries. HCPCS Level II codes are alphanumeric codes, consisting of a letter followed by four numbers. These codes, which CMS developed, represent products, supplies, and services used outside a physician's office (e.g., ambulance services and durable medical equipment).

We began the categorization by modeling some of the service categories after AMA's CPT code delineations: evaluation and management, anesthesia, surgery (which we modified and renamed major and minor medical procedures), radiology and imaging, pathology and laboratory, and medicine (which we modified and renamed therapy services). We then added eight categories—many of which were derived from the BETOS system and others that we created for this review—representing a variety of services that allowed for a detailed description of Part B services: endoscopy; oncology; dialysis services; transportation services; drugs and biologicals; enteral and parenteral therapy; durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS); and other. Listed below are the 14 service categories, including an other category for codes that do not readily fit into the previous 13 categories, and the number of HCPCS codes associated with each service category during 2008:

1. *Evaluation and management* comprised 240 HCPCS codes and includes services occurring during medical visits. These may include visits to physician offices, outpatient facilities, emergency rooms, nursing homes, etc.

2. *Anesthesia* comprised 213 HCPCS codes relating to anesthesia services necessary for a wide range of surgical and medical procedures. These services are organized by body location, such as upper body, lower body, and systemic.

3. *Major and minor medical procedures* comprised 3,166 HCPCS codes for services ranging from minor surgery (e.g., nail debridement) to organ transplants. We sorted the services in this category by the body systems in which the services were associated, such as integumentary (i.e., skin), musculoskeletal, and respiratory.

4. *Endoscopy* comprised 387 HCPCS codes related solely to endoscopy and related services, sorted primarily by the related body systems.

5. *Oncology* comprised 102 HCPCS codes and includes cancer treatments, such as radiation therapy and chemotherapy.

6. *Dialysis services* comprised 16 HCPCS codes and includes all nonsurgical services related to the provision of hemodialysis and peritoneal dialysis.

7. *Radiology and imaging* comprised 587 HCPCS codes and includes all imaging modalities and related supplies.

8. *Pathology and laboratory* comprised 1,091 HCPCS codes arranged by type of testing (e.g., therapeutic drug testing and urinalysis).

9. *Transportation services* comprised 18 HCPCS codes sorted by type and purpose of transport (e.g., nonemergency transport, air ambulance, and advanced life support).

10. *Drugs and biologicals* comprised 556 HCPCS codes divided by type of drug or biological, route of administration, purpose of administration, and dosage.

11. *Therapy services* comprised 117 HCPCS codes and includes those services subject to consolidated billing requirements regardless of Part A coverage, such as physical therapy, occupational therapy, and speech-language pathology services, as well as other therapies, such as acupuncture.

12. *Enteral and parenteral therapy* comprised 36 HCPCS codes divided by feeding type (i.e., enteral or parenteral). All codes associated with these services fall under this category, including pumps and supplies, as they can only be utilized for these specific services.

13. *DMEPOS* comprised 1,589 HCPCS codes, including a variety of products (e.g., crutches and pacemakers).

14. *Other* comprised 76 HCPCS codes and includes all services not in another category, such as miscellaneous codes that end in 99, the Not Otherwise Classified codes.

APPENDIX C

Table C-1: Payment and Utilization Statistics for 14 Medicare Part B Service Categories and Their Subcategories During Non-Part A Stays in 2008*

Service Category	Part B Payment	Total Part B Percentage of Payment	Number of Beneficiaries Who Received These Services	Percentage of Beneficiaries Who Received These Services	Average Payment per Beneficiary
Therapy services	**$1,314,988,128**	**27%**	**731,356**	**48%**	**$1,798**
Physical therapy, occupational therapy, and speech-language pathology services **	$1,299,187,587	26.62	674,006	44.54	$1,928
Hydration, therapeutic, prophylactic	$14,142,113	0.29	126,311	8.35	$112
Alternative therapies	$1,255,790	0.03	5,229	0.35	$240
Other physical medicine and rehabilitation	$263,954	0.01	255	0.02	$1,035
Evaluation and management	**$1,049,333,598**	**21%**	**1,415,945**	**94%**	**$741**
Nursing home visits	$592,916,446	12.15	1,302,679	86.09	$455
Psychiatry and alcohol/drug treatment	$177,587,963	3.64	365,799	24.17	$485
Emergency room visits	$100,104,236	2.05	329,957	21.80	$303
Office visits or other outpatient visits	$95,877,111	1.96	494,338	32.67	$194
Consultations	$48,098,605	0.99	314,471	20.78	$153
Hospital visits	$16,606,655	0.34	59,380	3.92	$280
Home visits	$8,384,883	0.17	51,193	3.38	$164
Special evaluation and management services	$5,647,600	0.12	1,517	0.10	$3,723
Preventive medicine services	$2,902,604	0.06	26,339	1.74	$110
Care plan oversight services	$877,306	0.02	5,806	0.38	$151
Prolonged services	$236,244	<0.01	2,687	0.18	$88
Major and minor medical procedures	**$464,983,013**	**10%**	**1,290,463**	**85%**	**$360**
Cardiovascular system	$168,377,920	3.45	1,164,323	76.94	$145
Integumentary system	$126,353,521	2.59	803,733	53.11	$157
Eye and ocular adnexa	$88,995,776	1.82	381,048	25.18	$234
Musculoskeletal system	$21,382,578	0.44	64,989	4.29	$329
Nervous system	$19,092,286	0.39	31,783	2.10	$601
Urinary system	$12,871,508	0.26	65,632	4.34	$196
Digestive system	$10,402,129	0.21	25,409	1.68	$409
Respiratory system	$8,348,420	0.17	44,709	2.95	$187
Auditory system	$6,235,558	0.13	89,904	5.94	$69
Male genital system	$1,121,210	0.02	1,738	0.11	$645
Female genital system	$941,551	0.02	4,614	0.30	$204
Hemic and lymphatic systems	$515,118	0.01	1,336	0.09	$386
General	$187,754	0.00	1,231	0.08	$153
Endocrine system	$151,870	0.00	196	0.01	$775

Table C-1 (continued)

Service category	Part B Payment	Total Part B Percentage of Payment	Number of Beneficiaries Who Received These Services	Percentage of Beneficiaries Who Received These Services	Average Payment per Beneficiary
Pathology and laboratory	**$394,283,013**	**8%**	**1,286,796**	**85%**	**$306**
Chemistry	$113,034,126	2.32	992,918	65.62	$114
Organ or disease oriented panels	$66,282,999	1.36	1,120,218	74.03	$59
Hematology and coagulation	$65,504,531	1.34	1,087,294	71.85	$60
Microbiology	$52,014,953	1.07	703,114	46.46	$74
Specimen procurement and other lab procedures	$39,719,213	0.81	695,837	45.98	$57
Therapeutic drug assays	$20,704,983	0.42	275,428	18.20	$75
Surgical pathology	$13,110,663	0.27	79,319	5.24	$165
Transfusion medicine	$9,558,217	0.20	27,558	1.82	$347
Urinalysis	$7,376,217	0.15	670,406	44.30	$11
Immunology	$3,566,365	0.07	86,812	5.74	$41
Cytopathology	$1,858,331	0.04	15,337	1.01	$121
Drug testing	$840,328	0.02	6,414	0.42	$131
Cytogenetic studies	$377,898	0.01	999	0.07	$378
Other procedures	$298,535	0.01	9,857	0.65	$30
Transportation services	**$374,453,747**	**8%**	**339,282**	**22%**	**$1,104**
Basic life support	$197,279,881	4.04	235,926	15.59	$836
Air ambulance	$105,453,234	2.16	268,504	17.74	$393
Transportation unit charges	$65,337,634	1.34	336,973	22.27	$194
Advanced life support	$4,877,542	0.10	13,347	0.88	$365
Other ambulance	$1,499,312	0.03	1,121	0.07	$1,337
Radiology and imaging	**$286,748,086**	**6%**	**862,805**	**57%**	**$332**
Radiology	$266,513,508	5.46	843,767	55.76	$316
Nuclear medicine	$11,870,967	0.24	26,513	1.75	$448
Ultrasound	$7,912,786	0.16	82,264	5.44	$96
Ultrasound guidance	$450,826	0.01	8,098	0.54	$56
Dialysis services	**$264,308,170**	**5%**	**31,254**	**2%**	**$8,457**
Miscellaneous dialysis procedures	$233,599,442	4.79	28,622	1.89	$8,162
End-stage renal disease services	$29,054,327	0.60	26,086	1.72	$1,114
Other dialysis modality	$1,208,890	0.02	220	0.01	$5,495
Hemodialysis	$421,458	0.01	1,672	0.11	$252
Enteral and parenteral therapy	**$224,110,762**	**5%**	**55,677**	**4%**	**$4,025**
Enteral formulae and enteral medical supplies	$223,584,867	4.58	55,650	3.68	$4,018
Parenteral nutrition solutions and supplies	$525,895	0.01	35	0.00	$15,026
Durable medical equipment, prosthetics, orthotics, and supplies	**$212,940,491**	**4%**	**374,099**	**25%**	**$569**
Medical supplies and surgical dressings	$82,401,913	1.69	127,697	8.44	$645
Durable medical equipment	$56,776,856	1.16	194,421	12.85	$292

Table C-1 (continued)

Service category	Part B Payment	Total Part B Percentage of Payment	Number of Beneficiaries Who Received These Services	Percentage of Beneficiaries Who Received These Services	Average Payment per Beneficiary
Orthotic devices	$38,647,969	0.79	104,649	6.92	$369
Medical supplies and surgical dressings	$35,113,752	0.72	14,680	0.97	$2,392
Drugs and biologicals	**$211,725,750**	**4%**	**420,721**	**28%**	**$503**
Drugs and biologicals administration	$169,857,996	3.48	117,280	7.75	$1,448
Chemotherapy drugs	$26,032,007	0.53	8,852	0.58	$2,941
Vaccines and toxoids	$6,537,200	0.13	306,501	20.25	$21
Immunization administration for vaccines	$6,383,368	0.13	326,012	21.54	$20
Nonprescription drugs	$1,457,997	0.03	8,725	0.58	$167
Oral medications	$747,470	0.02	673	0.04	$1,111
Pharmacy fees	$699,934	0.01	10,116	0.67	$69
Endoscopy	**$45,997,999**	**1%**	**130,716**	**9%**	**$352**
Digestive system	$25,053,556	0.51	37,679	2.49	$665
Urinary system	$12,137,564	0.25	17,614	1.16	$689
Eye and ocular adnexa	$4,892,780	0.10	71,526	4.73	$68
Respiratory system	$2,710,009	0.06	11,197	0.74	$242
Musculoskeletal system	$651,917	0.01	295	0.02	$2,210
Female genital	$514,498	0.01	667	0.04	$771
Oncology	**$26,110,191**	**1%**	**12,614**	**1%**	**$2,070**
Radiation oncology	$22,223,359	0.46	4,840	0.32	$4,592
Chemotherapy administration	$3,886,832	0.08	8,500	0.56	$457
Anesthesia	**$10,271,963**	**<1%**	**62,789**	**4%**	**$164**
Upper body	$7,339,343	0.15	43,844	2.90	$167
Lower body	$2,432,080	0.05	17,412	1.15	$140
Systemic	$500,540	0.01	4,215	0.28	$119
Other	**$381,402**	**<1%**	**2,958**	**<1%**	**$129**
Total	**$4,880,636,313**	**100%**	**1,511,974*** **	**—**	**—**

Source: Office of Inspector General analysis of paid Part B services during non-Part A stays in 2008.

* We only included those subcategories with total payments greater than $100,000.

** Physical therapy, occupational therapy, and speech-language pathology services include all services subject to consolidated billing requirements regardless of Part A coverage.

*** The total number of unique nursing home residents who received any Part B service during non-Part A stays in 2008.

APPENDIX D

Table D-1: Payment (In Millions) Across Places of Service For 14 Medicare Part B Service Categories During Non-Part A Stays in 2008

Service Category	Nursing Home	Outpatient Hospital	End-Stage Renal Disease Treatment Facility	Ambulance	Physician Office	Independent Laboratory	Other*	Total
Therapy services	$1,271	$20	$13	$0	$5	<$1	$7	**$1,315**
	96.6%	1.5%	1%	0%	<1%	<1%	0.5%	**100%**
Evaluation and management	$704	$118	$52	<$1	$96	<$1	$80	**$1,049**
	67.1%	11.2%	4.9%	<1%	9.1%	<1%	7.6%	**100%**
Major and minor medical procedures	$130	$186	<$1	<$1	$93	$9	$46	**$465**
	28%	40.1%	<1%	<1%	20.1%	2%	9.9%	**100%**
Pathology and laboratory	$32	$131	$1	<$1	$9	$193	$28	**$394**
	8.1%	33.2%	<1%	<1%	2.3%	48.9%	7.1%	**100%**
Transportation services	<$1	$12	$0	$360	<$1	$0	$2	**$374**
	<1%	3.2%	0%	96.2%	<1%	0%	<1%	**100%**
Radiology and imaging	$149	$83	<$1	$0	$26	<$1	$29	**$287**
	51.8%	28.9%	<1%	0%	9.2%	<1%	10%	**100%**
Dialysis services	<$1	$4	$259	$0	<$1	$0	<$1	**$264**
	<1%	1.6%	98%	0%	<1%	0%	<1%	**100%**
Enteral and parenteral therapy	$220	<$1	<$1	$0	$0	$0	$4	**$224**
	98.1%	<1%	<1%	0%	0%	0%	1.8%	**100%**
Durable medical equipment, prosthetics, orthotics, and supplies	$114	$1	$1	<$1	<$1	$0	$97	**$213**
	53.3%	<1%	<1%	<1%	<1%	0%	45.6%	**100%**
Drugs and biologicals	$11	$24	$124	<$1	$45	<$1	$8	**$212**
	5%	11.5%	58.6%	<1%	21.3%	<1%	3.6%	**100%**
Endoscopy	$2	$30	<$1	$0	$7	$0	$6	**$46**
	4.7%	65.5%	<1%	0%	15.7%	0%	14%	**100%**
Oncology	<$1	$14	<$1	$0	$11	$0	$1	**$26**
	<1%	54.5%	<1%	0%	42.5%	0%	2.8%	**100%**
Anesthesia	<$1	$7	$0	$0	<$1	$0	$3	**$10**
	<1%	69.2%	0%	0%	<1%	0%	30%	**100%**
Other	<$1	<$1	<$1	$0	<$1	<$1	<$1	**<$1**
	4.8%	31.4%	22%	0%	34.3%	<1%	7.3%	**100%**
Total	**$2,632**	**$630**	**$451**	**$360**	**$294**	**$202**	**$311**	**$4,881**
	53.9%	**12.9%**	**9.2%**	**7.4%**	**6.0%**	**4.1%**	**6.4%**	**100%**

Source: Office of Inspector General analysis of paid Part B services during non-Part A stays in 2008.

* Other included a variety of settings, such as the home, ambulatory surgical centers, emergency rooms, custodial care facilities, mobile units, intermediate care facilities, assisted living facilities, community mental health centers, and home health agencies.