

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**HOSPITALS NATIONWIDE GENERALLY
DID NOT COMPLY WITH MEDICARE
REQUIREMENTS FOR BILLING
OUTPATIENT RIGHT HEART
CATHETERIZATIONS
WITH HEART BIOPSIES**

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Office of Inspector General

<https://oig.hhs.gov>

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EXECUTIVE SUMMARY

Hospitals nationwide generally did not comply with Medicare requirements for billing outpatient right heart catheterizations and heart biopsies provided during the same patient encounter, resulting in estimated overpayments of \$7.6 million over approximately 2 years.

WHY WE DID THIS REVIEW

Prior Office of Inspector General reviews have found that some hospitals did not comply with Medicare billing requirements because they included the modifier -59, which indicates that a procedure is separate and distinct from another procedure performed on the same patient on the same day when the procedures performed were not separate and distinct. In particular, some hospitals incorrectly billed outpatient right heart catheterizations (RHCs) that were performed during the same patient encounter as endomyocardial biopsies (heart biopsies). By appending modifier -59 to the Healthcare Common Procedure Coding System (HCPCS) code, these hospitals represented that the RHCs were separate and distinct from the heart biopsies; however, the payment for a heart biopsy is generally intended to cover an RHC when the RHC is performed during the same encounter.

The objective of this review was to determine whether hospitals nationwide complied with Medicare requirements for billing outpatient RHCs and heart biopsies performed during the same patient encounter for calendar years (CYs) 2011 through 2012 (audit period).

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) developed the National Correct Coding Initiative (NCCI) to promote correct coding by providers and to prevent Medicare payments for improperly coded services. The NCCI edits include procedure-to-procedure edits that define pairs of HCPCS/Current Procedural Terminology (CPT) codes (code pairs) that generally should not be reported together for the same beneficiary on the same date of service. One function of the procedure-to-procedure edits is to prevent payments for codes that report overlapping services except in those instances where the services are “separate and distinct” (e.g., different session or patient encounter). Typically, a NCCI edit would prevent the payment for an RHC when billed on the same claim as a heart biopsy. However, under certain circumstances, a hospital may bill and get paid for both services in an NCCI code pair by including a modifier on the claim. If a hospital included modifier -59, it would bypass the NCCI edit and receive payment for both procedures as though they were performed separately. A hospital should not append modifier -59 to the HCPCS representing an RHC when it is performed with a heart biopsy unless the procedures are separate and distinct.

A heart biopsy is the removal of a small piece of the heart for examination that is done through a catheter (a small thin tube) that is threaded into the heart (cardiac catheterization). An RHC with heart biopsy is performed routinely after heart transplantation to monitor for signs of rejection and to assess heart function. In addition to obtaining heart tissue samples for testing, the RHC

measures hemodynamic pressures in the heart and lungs and determines how well the heart is pumping. When the main purpose of the RHC is to obtain a heart biopsy, the RHC is considered to be part of the heart biopsy for payment purposes.

Our audit covered \$11,156,563 in Medicare payments to 140 hospitals nationwide for 6,018 RHC line items that were potentially at risk for billing errors. The hospitals billed these RHCs as separate and distinct from heart biopsies performed for the same beneficiary on the same date of service. We selected for review a stratified random sample of 100 RHC line items with payments totaling \$182,410 for the audit period.

Upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (the 60-day rule). The Office of Inspector General believes that this audit report constitutes credible information of potential overpayments.

WHAT WE FOUND

Hospitals nationwide complied with the Medicare requirements for billing outpatient RHCs and heart biopsies provided during the same patient encounter for 8 of the 100 sampled line items. However, the hospitals did not comply with the Medicare requirements for 92 of the 100 sampled line items. Specifically, the hospitals incorrectly appended modifier -59 to the HCPCs code, representing that the RHCs were separate and distinct procedures from the heart biopsies even though the medical record documentation did not support the use of the modifier. As a result, the hospitals received overpayments of \$122,031. The errors occurred because the hospitals incorrectly considered the procedures separate and distinct when they performed additional steps, such as measuring hemodynamic pressures.

On the basis of our sample results, we estimated that hospitals nationwide received overpayments totaling \$7,629,229 for the audit period.

WHAT WE RECOMMEND

We recommend that CMS instruct the Medicare contractors to:

- educate hospitals on how to appropriately bill for RHCs performed during the same patient encounter as heart biopsies, which could have resulted in savings totaling an estimated \$7,629,229 over a 2-year period;
- identify claims in the years subsequent to our audit period that did not meet Medicare payment requirements and recover any associated overpayments; and
- notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General reviews have found that some hospitals did not comply with Medicare billing requirements because they included the modifier -59, which indicates that a procedure is separate and distinct from another procedure performed on the same patient on the same day when the procedures performed were not separate and distinct. In particular, some hospitals incorrectly billed outpatient right heart catheterizations (RHCs) that were performed during the same patient encounter as endomyocardial biopsies (heart biopsies). By appending modifier -59 to the Healthcare Common Procedure Coding System (HCPCS) code, these hospitals represented that the RHCs were separate and distinct from the heart biopsies; however, the payment for a heart biopsy is generally intended to cover an RHC when the RHC is performed during the same encounter.

OBJECTIVE

Our objective was to determine whether hospitals nationwide complied with Medicare requirements for billing outpatient RHCs and heart biopsies performed during the same patient encounter for calendar years (CYs) 2011 through 2012.

BACKGROUND

The Medicare Program

Medicare Part B provides supplementary medical insurance for medical and other health services, including hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers Medicare.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Hospital Outpatient Prospective Payment System

Under the outpatient prospective payment system (OPPS), Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses HCPCS codes and descriptors to identify and group the services within each APC group.¹ All services and items within an APC group are comparable clinically and require comparable resources. The RHC and heart biopsy procedures in this review were performed on an outpatient basis.

¹ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Medicare Requirements for Hospital Claims and Payments

The Medicare Claims Processing Manual (the Manual) requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly (Pub. No. 100-04, chapter 1, § 80.3.2.2).

Heart Biopsies, Heart Catheterizations, and Right Heart Catheterizations

A heart biopsy is the removal of a small piece of the heart for examination that is done through a catheter (a small thin tube) that is threaded into the heart (cardiac catheterization).² An RHC with heart biopsy is performed routinely after heart transplantation to monitor for signs of rejection and to assess heart function. In addition to obtaining heart tissue samples for testing, the RHC measures hemodynamic pressures in the heart and lungs and determines how well the heart is pumping.³ Cardiac output and hemodynamic pressure measurements are routinely obtained during cardiac catheterization procedures. During an RHC, as the catheter is advanced into the pulmonary artery, the physician measures pressures in the right upper and lower heart chambers. The biopsy portion of the procedure is usually performed at the end of the RHC. When the main purpose of the RHC is to obtain a heart biopsy, the RHC is considered to be part of the heart biopsy for payment purposes.

National Correct Coding Initiative and Procedure-to-Procedure Claims Processing Edits

CMS developed the National Correct Coding Initiative (NCCI) to promote correct coding by providers and to prevent Medicare payments for improperly coded services.⁴ Medicare contractors implemented NCCI edits within their claims-processing systems for the dates of service on or after January 1, 1996. The *NCCI Policy Manual for Medicare Services* (NCCI Manual) is a general reference that explains the rationale for NCCI edits. The NCCI Manual explains that it is inappropriate to separately report services that, based on the standards of medical/surgical practice, are integral to another procedure (i.e., primary and secondary service code pairs) (NCCI Manual, Chapter 1 § (B)).

The NCCI edits include procedure-to-procedure edits that define pairs of HCPCS/CPT codes (code pairs) that generally should not be reported together for the same beneficiary on the same date of service. One function of the procedure-to-procedure edits is to prevent payments for codes that report overlapping services except in those instances in which the services are separate

² U.S. National Library of Medicine, National Institute of Health, *Myocardial biopsy*: MedlinePlus Medical Encyclopedia. Accessed at <http://www.nlm.nih.gov/medlineplus/ency/article/003873.htm> on September 14, 2016.

³ *Hemodynamics* is a branch of physiology that deals with the circulation of blood through the cardiovascular system. Hemodynamic monitoring is the continuous monitoring of the movement of blood and pressures being exerted in the veins, arteries, and chambers of the heart. It is based on the measurement of systemic, pulmonary arterial and venous pressures and of cardiac output (the amount of blood your heart pumps per minute).

⁴ The NCCI coding policies are based on coding conventions defined in the American Medical Association's *Current Procedural Terminology (CPT) Manual* (CPT Manual), national and local policies and edits, coding guidelines developed by national societies, a review of current coding practices, and an analysis of standard medical and surgical practices.

and distinct. All code pairs are arranged in a “column 1” (primary service) and “column 2” (secondary service) format. When a heart biopsy is performed with an RHC, the column 2 code (e.g., RHC) is generally not payable with the column 1 code (e.g., heart biopsy). Typically, an NCCI edit would prevent the payment for the RHC when billed on the same claim with a heart biopsy. However, under certain circumstances, a hospital may bill and get paid for both services in a NCCI code pair by including a modifier on the claim. If a hospital included modifier -59, the secondary service would bypass the NCCI edit and the hospital would receive payment for both procedures as though they were performed separately. A hospital should not append modifier -59 to the HCPCS representing the RHC when performed with a heart biopsy unless the procedures are separate and distinct.⁵

Under section 1128J(d) of the Social Security Act and 42 CFR part 401 subpart D (the 60-day rule), upon receiving credible information of a potential overpayment, providers must: (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (42 CFR 401.305(a)(2), (f) and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016)). The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$11,156,563 in Medicare payments to 140 hospitals nationwide for 6,018 RHC line items that were potentially at risk for billing errors. The hospitals billed these RHC procedures as separate and distinct from heart biopsies performed for the same beneficiary on the same date of service. We selected for review a stratified random sample of 100 RHC line items with payments totaling \$182,410 for CYs 2011 and 2012 (audit period).

We evaluated compliance with selected billing requirements and subjected all 100 RHC line items to medical review to determine whether the medical record documentation supported that the RHC procedures were separate and distinct from the heart biopsy procedures.

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 findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates.

⁵ Effective January 1, 2015, CMS established four new HCPCS modifiers to define subsets of the modifier -59. The four new HCPCS modifiers to selectively identify subsets of Distinct Procedural Services (-59 modifier) are: Modifier XE-Separate Encounter, Modifier XS-Separate Structure, Modifier XP-Separate Practitioner, Modifier XU-Unusual Non-Overlapping Service. CMS will continue to recognize modifier -59, but providers should use one of the more descriptive modifiers when it is appropriate (Pub 100-20, One Time Notification, Transmittal 1422 Aug. 15, 2014).

FINDINGS

Hospitals nationwide complied with the Medicare requirements for billing outpatient RHCs and heart biopsies provided during the same patient encounter for 8 of the 100 sampled line items. However, the hospitals did not comply with the Medicare requirements for 92 of the 100 sampled line items. Specifically, the hospitals incorrectly appended modifier -59 to the HCPC code, representing that the RHCs were separate and distinct procedures from the heart biopsies even though the medical record documentation did not support the use of the modifier. As a result, the hospitals received overpayments of \$122,031. The errors occurred because the hospitals incorrectly considered the procedures separate and distinct when they performed additional steps, such as measuring hemodynamic pressures.

On the basis of our sample results, we estimated that hospitals nationwide received overpayments totaling \$7,629,229 for the audit period.

INCORRECTLY BILLED RIGHT HEART CATHETERIZATIONS PERFORMED DURING THE SAME PATIENT ENCOUNTER AS HEART BIOPSIES

Use of Modifier -59 To Indicate a Distinct Procedural Service

“The ‘59’ modifier is used to indicate a distinct procedural service [T]his may represent a different session or patient encounter, different procedure or surgery, different site or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries)” (the Manual, chapter 23, § 20.9.1.1(B)). Further, modifier -59 is used to identify procedures or services that are not ordinarily reported together but are appropriate under the circumstances. There are limited situations in which two services may be reported as separate and distinct because they are separated in time and describe services that do not overlap even though they may occur during the same patient encounter. However, if the diagnostic procedure is an inherent component of the surgical procedure, it cannot be reported separately (NCCI Manual, chapter 1).

Hospitals Used Modifier -59 for Services That Were Not Distinct Procedural Services

For 92 of the 100 sampled line items, hospitals incorrectly billed for RHC procedures performed during the same patient encounter as heart biopsy procedures. For 87 of those claims, the hospitals incorrectly appended modifier -59 to the HCPC code, representing that the RHCs were separate and distinct procedures from the heart biopsies even though the medical record documentation did not support the use of the modifier.⁶ Although additional steps taken during the encounter, such as measuring hemodynamic pressures, may have been reasonable and necessary, the documentation showed that obtaining the heart biopsies was the primary purpose of the RHCs. Therefore, the RHCs were an inherent component of the heart biopsies, and the payments for the biopsies already covered the RHCs.

⁶ For 5 of the 92 sample items in error, the modifier -59 was not appended to either the heart biopsies or RHC code; however, both procedures were paid by Medicare. One Medicare contractor attributed this to the timing of the updates to the Medicare Code Editor/Outpatient Code Editor (MCE/OCE). The MCE/OCE updates are often applied retroactively.

For the remaining eight sampled line items, the hospitals correctly billed for RHC procedures performed during the same patient encounter as heart biopsy procedures. In these cases, the documentation showed there was a separate and distinct reason for the performance of the RHC beyond obtaining the heart biopsy. For example, for one sampled line item, the documentation showed that the RHC was performed to rule out myocardial dysfunction (not symptomatic of transplant rejection), and the biopsy was performed as part of routine heart transplant rejection surveillance. In other cases, the patient required a comprehensive assessment of cardiac function or there was evidence of another clinical concern other than heart transplant rejection.

The \$122,031 paid for RHCs performed during the same patient encounters as the heart biopsy procedures were overpayments because the hospitals' medical record documentation did not support the use of modifier -59. Officials at many of the hospitals said that the procedures were separate and distinct because they required additional steps that were reasonable and necessary, such as measuring hemodynamic pressures. However, even though the hospitals may have performed additional steps that were reasonable and necessary, Medicare payments for the heart biopsy procedures (the primary service) already included payments for the RHCs (a secondary service).

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that hospitals nationwide received Medicare overpayments totaling \$7,629,229 for the audit period.

RECOMMENDATIONS

We recommend that CMS instruct its Medicare contractors to:

- educate hospitals on how to appropriately bill for RHCs performed during the same patient encounter as heart biopsies, which could have resulted in savings totaling an estimated \$7,629,229 over a 2-year period;
- identify claims in the years subsequent to our audit period that did not meet Medicare payment requirements and recover any associated overpayments; and
- notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations. CMS stated it will continue to educate providers on the billing requirements. CMS said it will assign Medicare contractors to review years subsequent to the audit period and recover overpayments consistent with its policies and procedures. In addition, CMS said it will work with the Medicare contractors (based on CMS's operational capabilities) to notify providers of potential overpayments and track returned overpayments that the provider identifies in accordance with the 60-day rule.

CMS's comments appear in their entirety as Appendix D.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$11,156,563 in Medicare payments to 140 hospitals nationwide for 6,018 RHC line items that were potentially at risk for billing errors. The hospitals billed these RHC procedures as separate and distinct from heart biopsy procedures performed for the same beneficiary on the same date of service. We selected for review a stratified random sample of 100 RHC line items with payments totaling \$182,410 for CYs 2011 and 2012 (audit period).

We evaluated compliance with selected billing requirements and subjected all 100 RHC line items to medical review to determine whether the medical record documentation supported that the RHC procedures were separate and distinct from the heart biopsy procedures.

We limited our review of the hospitals' internal controls to those applicable to billing outpatient RHCs and heart biopsies performed during the same patient encounter because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our fieldwork from February 2014 through May 2014.

METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal laws, regulations, and Medicare contractor guidance;
- interviewed CMS officials to gain an understanding of the billing requirements for RHCs and heart biopsies;
- interviewed staff at two Medicare contractors to gain an understanding of their procedures for the processing and payment of claims for RHC procedures billed as separate and distinct from another procedure performed during the same patient encounter;
- used CMS's NCH to extract outpatient claims submitted by hospitals nationwide for RHC and heart biopsy procedures billed on the same claim for the same beneficiary and date of service during our audit period;
- identified 6,018 RHC line items corresponding to a heart biopsy procedure;
- selected a stratified random sample of 100 RHC line items for detailed review (Appendix B);

- reviewed available data from CMS’s Common Working File for the sampled line items to determine whether the claims had been canceled or adjusted;
- contacted representatives from the 48 hospitals that billed for the sampled line items to obtain an understanding of the hospitals’ policies and procedures for billing RHCs and heart biopsies performed during the same patient encounter;
- obtained and reviewed billing and medical record documentation provided by the hospitals to support the sampled line items;
- used an independent medical review contractor to determine whether the 100 sampled RHC line items were separate and distinct from the heart biopsy procedures;
- calculated the correct payment for those sampled line items requiring adjustments;
- used the results of the sample to estimate the total Medicare overpayments to the hospitals for our audit period (Appendix C); and
- discussed the results of our review with CMS 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 findings and conclusions based on our audit objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of outpatient claims that were submitted by hospitals nationwide for services provided to Medicare beneficiaries during CYs 2011 and 2012 for claims in which the hospitals billed the RHC procedures as separate and distinct when the procedures were provided to beneficiaries who also received heart biopsy procedures during the same patient encounter.

SAMPLING FRAME

Using CMS's National Claims History file data for CYs 2011 and 2012, we extracted claims containing line item information for RHC and heart biopsy procedures that were billed on the same claim for the same beneficiary and date of service. We analyzed these claims and removed RHC line items that met one or more of the following criteria:

- the RHC or related heart biopsy line provider payment amount was zero,
- the providers that submitted the associated claim were under investigation by the OIG's Office of Investigations,
- the providers were under review by other entities, and
- the line items were duplicates.

The final sampling frame consisted of 6,018 RHC line items with payments totaling \$11,156,563.

SAMPLE UNIT

The sample unit was an RHC line item.

SAMPLE DESIGN

We used a stratified random sample.

Stratum	Amount Range of RHC Line Paid to Provider	Number of Line Items	Total Dollar Value of Line Items
1	\$0.74 - \$1,755.99	1,104	\$1,457,754
2	\$1,756 - \$2,015.99	3,113	\$5,828,947
3	\$2,016 - \$3,256.85	1,801	\$3,869,862
Totals		6,018	\$11,156,563

SAMPLE SIZE

We randomly selected 30 RHC line items from stratum 1, 40 from stratum 2, and 30 from stratum 3. Our total sample size was 100 RHC line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum, and after generating the random numbers, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of Medicare overpayments paid to the hospitals nationwide during the audit period.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

OVERALL SAMPLE RESULTS

Stratum	Frame Size	Total Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Overpayments in Sample
1	1,104	\$1,457,754	30	\$43,807	26	\$25,570
2	3,113	\$5,828,947	40	\$74,014	37	\$50,439
3	1,801	\$3,869,862	30	\$64,589	29	\$46,022
Total	6,018	\$11,156,563	100	\$182,410	92	\$122,031

ESTIMATES

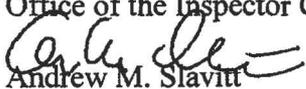
Estimates of Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)

Point Estimate	\$ 7,629,229
Lower Limit	\$ 7,235,768
Upper Limit	\$ 8,022,690



JAN 13 2017

To: Daniel R. Levinson
Inspector General
Office of the Inspector General

From: 
Andrew M. Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services

Subject: Hospitals Nationwide Generally Did Not Comply With Medicare Requirements For Billing Outpatient Right Heart Catheterizations With Heart Biopsies (A-01-13-00511)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report.

CMS is committed to providing Medicare beneficiaries with high quality health care and protecting taxpayer dollars by preventing improper payments. CMS has taken actions to prevent Medicare overpayments, including educating providers on proper billing and implementing system edits. CMS educates providers on how to avoid billing errors through a variety of channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. In addition, CMS conducts prepayment and post-payment claim reviews to identify and address incorrect billing caused by coverage or coding errors made by providers.

OIG's recommendations and CMS's responses are below.

OIG Recommendation

The OIG recommends that CMS educate hospitals on how to appropriately bill for RHCs performed during the same patient encounter as heart biopsies, which could have resulted in savings totaling an estimated \$7,629,229 over a two year period.

CMS Response

CMS concurs with this recommendation. CMS routinely educates providers on avoiding Medicare billing errors through various channels, including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. CMS will continue to use channels such as these to educate providers on these requirements.

OIG Recommendation

The OIG recommends that CMS identify claims in the years subsequent to the audit period that did not meet Medicare payment requirements and recover any associated overpayments.

CMS Response

CMS concurs with this recommendation. CMS will assign Medicare contractors to review subsequent years to the audit period to determine if there are claims that did not meet Medicare payment requirements. CMS will recover overpayments consistent with the agency's policies and procedures.

OIG Recommendation

The OIG recommends that CMS notify providers of potential overpayments so that those providers can exercise reasonable diligence to investigate and return any identified overpayments, in accordance with the 60-day rule, and identify and track any returned overpayments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will work with the Medicare contractors to notify providers of potential overpayments related to this report, and track returned overpayments that the provider identifies in accordance with the 60-day rule related to this report based on CMS' operational capabilities.