

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE PAID NEW ENGLAND
PROVIDERS TWICE FOR NONPHYSICIAN
OUTPATIENT SERVICES PROVIDED
SHORTLY BEFORE OR DURING
INPATIENT STAYS**

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Gloria L. Jarmon
Deputy Inspector General
for Audit Services

June 2017
A-01-15-00511

Office of Inspector General

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Report in Brief

Date: June 2017

Report No. A-01-15-00511

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Review

Under the Medicare Part A Inpatient Prospective Payment System (IPPS), hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. Included in these services are most nonphysician outpatient services provided either within the 3 days prior to the inpatient admission, on the date of admission, or during the hospital stays.

Prior OIG reviews identified significant overpayments to hospital outpatient providers for nonphysician services furnished shortly before or during inpatient stays. The Centers for Medicare & Medicaid Services generally concurred with recommendations in these reports and implemented them. However, recent claims data indicated that overpayments for these services might still be occurring.

Our objective was to determine whether Medicare payments made by National Government Services (NGS) to hospital outpatient providers, were correct for nonphysician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge) in calendar year (CY) 2013 and CY 2014.

How OIG Did This Review

We selected a stratified random sample of 129 nonphysician outpatient services furnished within 3 days prior to the date of admission, on the date of admission, or during IPPS stays.

Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays

What OIG Found

Medicare payments made by NGS to hospital outpatient providers were not always correct for nonphysician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge). Medicare payments were correct for 54 of the 129 nonphysician outpatient services that we sampled. However, for 75 services we sampled, NGS paid 41 providers twice—as part of the IPPS payment and the Part B payment—which resulted in total overpayments of \$288,000. These errors occurred because providers did not understand Medicare requirements, provider controls failed to prevent or detect incorrect billing, and providers were unaware that beneficiaries were inpatients at other facilities. In addition, Medicare payment system controls did not prevent or detect overpayments for incorrectly billed services. On the basis of our sample results, we estimated that because of these errors NGS made at least \$1.3 million in overpayments to hospital outpatient providers during CY 2013 and CY 2014. An estimated \$1 million (\$1,324,893 - \$287,655) was paid to 129 providers who submitted the remaining 21,606 nonsampled line items.

What OIG Recommends and NGS Comments

We made recommendations to NGS that it recover the portion of the \$288,000 in identified overpayments from the 41 providers for the 75 incorrectly billed services that are within the 4-year reopening period; notify the 41 providers of potential additional 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; notify the 129 providers responsible for the remaining 21,606 nonsampled line items with potential overpayments estimated at \$1 million 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; and educate all of its providers of their responsibilities under Medicare requirements to bill accurately for inpatient and outpatient services to prevent improper payments.

NGS agreed with our first, second, and fourth recommendations; however, NGS did not agree with our third recommendation as originally written, due to the level of effort and associated costs. After consideration of NGS's comments, we have changed our third recommendation, and NGS has fully concurred with all of our recommendations.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews identified significant overpayments to hospital outpatient providers for nonphysician services furnished shortly before or during inpatient stays. In those reviews, we had recommended that the Centers for Medicare & Medicaid Services (CMS) recover overpayments, ensure that edits to prevent such overpayments were in place and working properly, and educate providers on the proper billing of nonphysician outpatient services. CMS generally concurred with our recommendations and implemented them. (See Appendix A for list of related reports.) However, our analysis of recent claims data indicated that overpayments for these services might still be occurring.

OBJECTIVE

Our objective was to determine whether Medicare payments made by National Government Services (NGS) to hospital outpatient providers were correct for nonphysician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during inpatient prospective payment system (IPPS) stays (excluding date of discharge).

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act (the Act) in 1965, provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Medicare Part A helps cover inpatient care in hospitals. Medicare Part B helps cover physician services and outpatient care. CMS administers the program.

The Inpatient Prospective Payment System

Under the Medicare Part A IPPS, hospitals are paid a predetermined amount per discharge for inpatient hospital services furnished to Medicare beneficiaries. The prospective payment amount represents the total Medicare payment for the inpatient operating costs associated with a beneficiary's hospital stay.¹ Inpatient operating costs include routine services, ancillary services (e.g., radiology and laboratory services), special care unit costs, malpractice insurance costs, and preadmission services. Accordingly, hospitals generally receive no additional payments for nonphysician outpatient services furnished shortly before and during inpatient stays. Medicare makes a duplicate payment if it makes a separate Part B payment to providers for such nonphysician outpatient services.

¹ In addition to payments based on the prospective payment rates for inpatient operating costs, hospitals can also receive payments for the costs related to outlier cases, graduate medical education, certain items excluded from the prospective payment rates, bad debts, serving a significant number of end-stage renal disease beneficiaries, serving a disproportionate share of low-income patients, and blood clotting factor furnished to hemophilia patients.

Medicare Requirements for Provider Claims and Payments

Medicare requirements state that most nonphysician outpatient services (i.e., emergency room services, observation services, laboratory tests, x-rays, and other radiology services) provided within 3 days prior to the date of admission, on the date of admission, or during the hospital stays must be included in the IPPS payment (the Act § 1886(a)(4)). Medicare has some exceptions to these requirements (42 CFR, chapter IV § 412.2 c(5)(ii) and (iv)). Appendix B contains the details of the Medicare requirements.

Under section 1128J(d) of the 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)). OIG believes this audit report constitutes credible information of potential overpayments.

Medicare Contractors and Medicare Claims Processing Systems

CMS relies on Medicare administrative contractors (MACs) to process and pay Medicare inpatient and outpatient claims from hospitals. Each Medicare contractor is responsible for processing claims submitted by hospitals within 1 of 12 designated regions, or jurisdictions, of the United States and its territories. MACs are also responsible for educating providers on Medicare billing requirements.

MACs use the Fiscal Intermediary Standard System (FISS) to process inpatient and outpatient claims submitted by hospitals in their designated jurisdictions. After being processed through the FISS, and prior to payment, all MAC claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization. Once the CWF has processed a claim, it electronically transmits information to the MAC, including information regarding potential errors on the claim.

Both the FISS and CWF systems contain edits to prevent and detect overpayments for nonphysician outpatient services furnished shortly before and during inpatient stays.

National Government Services

On February 22, 2013, CMS announced that National Government Services, Inc. (NGS), had been awarded the Jurisdiction K contract for the administration of Medicare Part A and Part B fee-for-service claims in the States of Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont. NGS services approximately 217,000 Part B practitioners and suppliers, nearly 500 hospitals, and more than 500 home health and hospice providers.

HOW WE CONDUCTED THIS REVIEW

Our audit covered 21,735 line items for nonphysician outpatient services submitted by 130 New England providers within 3 days prior to the date of admission, on the date of admission, or during (excluding date of discharge) IPPS stays and valued at \$6,164,038 for calendar year (CY) 2013 and CY 2014. We selected a stratified random sample of 129 line items.

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 C contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, and Appendix E contains our sample results and estimates.

FINDINGS

Medicare payments made by NGS to hospitals for outpatient services were not always correct for nonphysician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge). Medicare payments were correct for 54 of the 129 nonphysician outpatient services that we sampled. However, for 75 services we sampled, NGS paid 41 providers twice—as part of the IPPS payment and the Part B payment—which resulted in total overpayments of \$287,655. These errors occurred because providers did not understand Medicare requirements, provider controls failed to prevent or detect incorrect billing, and providers were unaware that beneficiaries were inpatients at other facilities.² In addition, Medicare payment system controls did not prevent or detect overpayments for incorrectly billed services.

On the basis of our sample results, we estimated that because of these errors NGS made at least \$1.3 million in overpayments to hospital outpatient providers during CY 2013 and CY 2014.³

HOSPITALS INCORRECTLY BILLED OUTPATIENT SERVICES

Medicare requirements state that most nonphysician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during the hospital stays must be included in the IPPS payment (The Act § 1886(a)(4)). Medicare has some exceptions to these requirements (42 CFR, chapter IV § 412.2 c(5)(ii) and (iv)). Appendix B contains the details of the Medicare requirements.

² These are cases where the patient required services that the original hospital did not have the capability to perform.

³ An estimated \$1 million (\$1,324,893 - \$287,655) was paid to 129 providers who submitted the remaining 21,606 nonsampled line items (see Appendix E for sample results and estimates).

Providers incorrectly billed Medicare Part B for 75 of the 129 line items that we reviewed. The incorrectly billed line items were for services provided within 3 days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge). The incorrect billing resulted in overpayments totaling \$287,655.

On the basis of our sample results, we estimate that NGS made at least \$1,324,893 in overpayments for nonphysician outpatient services during the period of our review.

CAUSES OF OVERPAYMENTS

Providers attributed the incorrect billing of outpatient services to the following factors:

- For 42 of the 75 overpayments, totaling \$208,572, providers stated they did not understand Medicare requirements and incorrectly billed outpatient services as unrelated to the inpatient admission when the services were related.
- For 26 of the 75 overpayments, totaling \$48,935, providers stated the incorrect billing was the result of clerical errors during the patient admitting or billing process. For example, one provider stated that it had a manual system that failed to detect incorrect billing.
- For 7 of the 75 overpayments, totaling \$30,148, providers stated they were not aware that the beneficiaries were inpatients at other facilities. For example, one provider stated that a patient had come from a skilled nursing facility, but the patient had actually come from another hospital.

In addition, Medicare payment system controls did not prevent or detect overpayments for incorrectly billed services. NGS officials acknowledged situations in which it processed claims that did not activate prepayment edits designed to prevent improper payments. NGS officials stated that one of the reasons this happened was because previous prepayment edits had been disabled per CMS's instruction via Change Request 7142.7.⁴

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that NGS made at least \$1,324,893 in overpayments to hospital outpatient providers during CY 2013 and CY 2014 for services provided to beneficiaries within 3 days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge).

⁴ CMS issues Change Requests to alert providers and MACs of a change in policy or procedures.

RECOMMENDATIONS

We recommend that NGS:

- recover the portion of the \$287,655 in identified overpayments from the 41 providers for the 75 incorrectly billed services that are within the 4-year reopening period;
- notify the 41 providers of potential additional 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;
- notify the 129 providers responsible for the remaining 21,606 nonsampled line items with potential overpayments estimated at \$1 million 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; and
- educate all of its providers of their responsibilities under Medicare requirements to bill accurately for inpatient and outpatient services to prevent improper payments.

NATIONAL GOVERNMENT SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

NGS agreed with our first, second, and fourth recommendations; however, NGS did not agree with our original third recommendation as written. We took NGS's comments into consideration and agreed that the recommendation, as written, would be very burdensome for NGS because it recommended NGS to review 21,606 line items. As a result, we have changed our third recommendation so that it now recommends that NGS notify the providers to investigate these potential overpayments and return any identified overpayments. Based on NGS's comments to our original recommendation, and the new recommendation, both resulting in potential recoveries, NGS has fully concurred with all of our recommendations. NGS's comments are included in their entirety as Appendix F.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title⁵	Report Number	Issue Date
<i>Medicare Continues to Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay</i>	A-01-10-00508	06/14/12
<i>Follow-up Audit of Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System</i>	A-01-00-00506	07/31/01
<i>Improper Payments to Hospitals for Nonphysician Outpatient Services under the Prospective Payment System</i>	A-01-95-00508	05/23/96
<i>Expansion of the Diagnosis Related Group Payment Window</i>	A-01-92-00521	07/06/94

⁵ These reports are available at <http://oig.hhs.gov>.

Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays (A-01-15-00511)

APPENDIX B: MEDICARE REQUIREMENTS FOR THE PAYMENT OF OUTPATIENT SERVICES RELATED TO INPATIENT PROSPECTIVE PAYMENT SYSTEM STAYS

Inpatient hospital operating costs include all routine operating costs, ancillary service operating costs, and special care unit operating costs, and “includes the costs of all services for which payment may be made under this title that are provided by the hospital (or an entity wholly owned or operated by the hospital) to a patient during the 3 days immediately preceding the date of such admission if such services are diagnostic services or are other services related to the admission. Other services related to the admission includes all services that are not diagnostic services that are provided by a hospital (or an entity wholly owned or wholly operated by the hospital) to a patient on the date of the patient’s inpatient admission; or during the 3 days immediately preceding the date of such admission unless the hospital demonstrates that such services are not related to such admission” (the Act § 1886(a)(4)).

Inpatient operating costs include but are not limited to costs for routine services (such as room, board, routine nursing services), ancillary services (such as radiology and laboratory services provided to inpatients), and preadmission services provided on the date of or during the 3 days preceding the inpatient admission. This includes diagnostic services furnished after January 1, 1991, and nondiagnostic services furnished on or after June 25, 2010 (other than ambulance services and maintenance renal dialysis services), that the hospital does not attest as services that are unrelated to the beneficiary’s inpatient admission (42 CFR, chapter IV § 412.2 c(5)(ii) and (iv)).

APPENDIX C: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 21,735 line items for nonphysician outpatient services submitted by New England providers within 3 days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge) and valued at \$6,164,038 for CY 2013 and CY 2014.

Our objective did not require an understanding or assessment of the complete internal control structure of the providers or Medicare contractors that processed the claims. Therefore, we limited our review to (1) obtaining an understanding of providers' procedures for submitting claims for nonphysician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge); and (2) Medicare contractors' procedures for processing and paying claims for those nonphysician outpatient services.

Our fieldwork consisted of contacting the outpatient providers that billed for the items we sampled and the inpatient hospitals that billed for the associated IPPS stays. We also contacted NGS. We conducted our fieldwork from January 2016 through October 2016.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify nonphysician outpatient services provided within 3 days prior to the date of admission, on the date of admission, or during (excluding date of discharge) IPPS stays for CY 2013 and CY 2014;
- identified five strata from which we selected our sample items (see Appendix C for the details of the line items contained in each strata);
- selected a stratified random sample of 129 line items, 25 each from strata one and two, 30 each from strata three and four, and all 19 line items from stratum five (Appendix C), and, for the sampled line items, we:
 - reviewed available claims histories from the CWF for each nonphysician outpatient service and corresponding inpatient stay for the sampled line items, to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork and
 - contacted 70 providers that billed for the nonphysician outpatient services and/or the corresponding inpatient stays we sampled to validate payments, determine the underlying causes of improper billing, and verify the admission and discharge dates;

- contacted NGS to:
 - obtain an understanding of the billing requirements and edits in place in the FISS; and
 - submit 12 sample items in which the provider deemed the nonphysician outpatient service to be unrelated to the corresponding inpatient stay, for medical review (NGS determined that the nonphysician outpatient services provided for 2 of the 12 sample items submitted, were related to the corresponding inpatient stay);
- contacted the two providers to inform them of NGS's determination that the nonphysician outpatient services provided were related to the corresponding inpatient stays (upon further review, both providers agreed with NGS's determination);
- used our sample results to estimate the overpayments that NGS made for nonphysician outpatient services provided in CY 2013 and CY 2014 (Appendix D); and
- discussed the results of our review with NGS.

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 objective.

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of Medicare outpatient claims that were paid by NGS to outpatient providers in New England for nonphysician outpatient services, provided to beneficiaries within 3 days prior to the date of admission to, on the date of admission to, or during an IPPS stay (excluding date of discharge) during CY 2013 and CY 2014.

SAMPLING FRAME

We extracted a list of claims meeting the definition of our target population from the National Claims History file. To arrive at our sampling frame, we removed the following items from our file: (1) line items with paid amounts of less than \$5.00 and (2) line items for certain ambulance services that, based on additional information on the claim, likely contained date of service errors. The final sampling frame contained 21,735 line items for nonphysician outpatient services submitted by New England providers during our audit period, totaling \$6,164,038.

SAMPLE UNIT

The sample unit was a line item on a Medicare outpatient claim.

SAMPLE DESIGN

We used a stratified random sample as follows.

Stratum	Stratum Description	Number of Lines	Sample Size	Dollar Value of Line Payments
1	Frame Items On the Date of Admission, During, and 3 Days Prior (Without Condition code 51 ⁶ and With Condition Code 51 and Same Diagnosis Codes) to an IPPS admission – Low Dollar	3,364	25	\$435,392
2	Frame Items On the Date of Admission, During, and 3 Days Prior (Without Condition code 51 and With Condition Code 51 and same Diagnosis Codes) to an IPPS admission – High Dollar	151	25	\$263,545
3	Frame Items 3 Days Prior to Admission With Condition Code 51 and Different Diagnosis Codes –	17,197	30	\$2,739,886

⁶ Condition code “51 - Attestation of Unrelated Outpatient Non-diagnostic Services”

	Low Dollar			
4	Frame Items 3 Days Prior to Admission with Condition Code 51 and Different Diagnosis Codes – High Dollar	1,004	30	\$2,330,581
5	All Frame Items Paid >\$10,000	19	19	\$394,634
Totals		21,735	129	\$6,164,038

Strata one and two contained line items for outpatient services that were provided on the day of admission to or during an IPPS stay. They also contained line items for outpatient services provided within 3 days prior to the IPPS admission that were billed without condition code 51 and others that were billed with condition code 51 where the inpatient and outpatient principle diagnosis codes were the same.

Strata three and four contained line items for outpatient services that were provided within 3 days prior to the IPPS admission that were billed with condition code 51 where the inpatient and outpatient principle diagnosis codes were different.

SAMPLE SIZE

We randomly selected 25 line items from strata one and two, and 30 line items from strata three and four. We also reviewed all 19 line items in stratum five, for a total sample size of 129.

SOURCE OF RANDOM NUMBERS

We generated the random numbers for each stratum using the OIG/OAS Statistical Software.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in each stratum. After generating 25 random numbers for strata one and two and 30 random numbers for strata three and four, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Sample Results for Overpayments

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Overpayments	Value of Overpayments
1	3,364	\$ 435,392	25	\$ 2,134	25	\$ 2,134
2	151	263,545	25	39,676	23	33,450
3	17,197	2,739,886	30	4,283	7	609
4	1,004	2,330,581	30	65,756	9	22,233
5	19	394,634	19	394,634	11	229,229
Total	21,735	\$ 6,164,038	129	\$ 506,483	75	\$ 287,655

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

Point Estimate	\$ 1,811,671
Lower Limit	\$ 1,324,893
Upper Limit	\$ 2,298,450



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May 12, 2017

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Report Number: A-01-15-00511

Dear Mr. Lamir,

National Government Services (NGS) appreciates the opportunity to provide the following comments and the assessment of concurrence in response to the review of the Office of Inspector General's (OIG) draft report "Medicare Paid Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays." NGS acknowledges the errors discovered during this audit occurred because providers did not understand Medicare requirements, provider controls failed to prevent or detect incorrect billing, and providers were unaware that beneficiaries were inpatients at other facilities.

The following represents our response to the recommendations made in your report dated April 17, 2017:

Recommendation # 1 – Recover the portion of the \$287,655 in identified overpayments from the 41 providers for the 75 incorrectly billed services that are within the 4-year reopening period. NGS agrees with this recommendation to recover the overpayments. The claims would be adjusted and recoupments tracked for reporting.

Recommendation # 2 – Notify the 41 providers of potential additional 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.

NGS agrees with this recommendation. NGS would issue self-review letters to the 41 providers which would instruct the providers to investigate and return any identified overpayments. NGS would provide targeted education regarding the provider's responsibility to accurately bill for inpatient and outpatient services.

A CMS Medicare Administrative Contractor

Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays (A-01-15-00511)



NGS would receive self-audited overpayments or voluntary refunds that are found within the standard system. NGS would monitor and process the workload under normal workload processes. If special reporting is needed, it can be incorporated into the process.

Recommendation # 3 – Review the remaining 21,606 nonsampled line items with potential overpayments estimated at \$1 million and recover overpayments to the extent allowed under the law.

NGS disagrees with this recommendation as written. Due to the level of effort and associated costs to complete complex review on this volume of claims, NGS suggests instead that we utilize a similar process the OIG followed in having the provider review the billed claims for accuracy. NGS would issue self-review letters to the impacted providers. Partnered with education, this letter would instruct providers to complete a self-review of the impacted claims and provide feedback to NGS. Any claim identified as needing correction would be adjusted by NGS and any overpayments recouped.

Recommendation # 4 – Educate all of its providers of their responsibilities under Medicare requirements to bill accurately for inpatient and outpatient services to prevent improper payments.

NGS agrees with this recommendation. NGS would conduct general training for all providers on the rules and accurate billing procedures for inpatient and outpatient services. This would include enhancing our web site materials and job aids, conducting webinars and seminars. We would partner with our POE Advisory Group and our hospital associations to share information with their membership hospitals.

Sincerely,

/Andrew Conn/

Andrew Conn
Jurisdiction K Program Manager