Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE MADE $11.7 MILLION IN OVERPAYMENTS FOR NONPHYSICIAN OUTPATIENT SERVICES PROVIDED SHORTLY BEFORE OR DURING INPATIENT STAYS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

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Report in Brief
Date: May 2020
Report No. A-01-17-00508

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

Medicare Made $11.7 Million in Overpayments for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays

Why OIG Did This Audit

Prior OIG audits identified significant overpayments to hospital outpatient providers for nonphysician services furnished shortly before or during inpatient stays. In those audits, we 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. However, our analysis of recent claim data indicated that overpayments for nonphysician outpatient services might still be occurring. We performed this audit as a followup to our previous work.

Our objective was to determine whether Medicare payments to hospital outpatient providers were correct for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during Inpatient Prospective Payment System (IPPS) stays (excluding date of discharge) for calendar years (CYs) 2016 and 2017.

How OIG Did This Audit

We identified inpatient claims from hospitals with service dates during the audit period. We used the beneficiary information and service dates from the inpatient claims to identify outpatient claims that overlapped with the inpatient claims for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays.

What OIG Found

Medicare made incorrect payments to outpatient providers for 40,984 nonphysician outpatient services provided nation-wide within 3 days before the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge) that we reviewed. These incorrect payments occurred because the Common Working File (CWF) edits were not designed to accurately identify all potentially incorrect claims.

As a result, Medicare made $11.7 million in incorrect payments to hospital outpatient providers during CYs 2016 and 2017. This includes claims beyond the 4-year reopening period. In addition, beneficiaries incurred $2.7 million in coinsurance and deductible liabilities related to these incorrect payments.

What OIG Recommends and CMS Comments

We recommend that CMS ensure that all necessary information is included in the CWF edits to accurately identify and prevent incorrect payments for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays. We also recommend that CMS direct the Medicare contractors to (1) recover the portion of $11.7 million in identified overpayments (for claims within the 4-year reopening period) resulting from the 40,984 incorrectly billed services; (2) instruct the outpatient providers to refund the portion of the $2,785,607 in deductible and coinsurance amounts (for claims within the 4-year reopening period) that may have been incorrectly collected from beneficiaries or from someone on their behalf; (3) notify the appropriate providers so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (4) educate outpatient providers on how to correctly bill nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays.

In written comments on our draft report, CMS concurred with all of our recommendations and described the actions that it had taken or planned to take to address them. For example, CMS stated that it is currently in the process of updating the automated system edits to accurately identify and prevent incorrect payments for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during inpatient hospital stays.

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INTRODUCTION

WHY WE DID THIS AUDIT

Prior Office of Inspector General (OIG) audits identified significant overpayments to hospital outpatient providers for nonphysician services furnished shortly before or during inpatient stays. In those audits, we 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 B for a list of related reports.) However, our analysis of recent claim data indicated that overpayments for nonphysician outpatient services might still be occurring. We performed this audit as a followup to our previous work.

OBJECTIVE

Our objective was to determine whether Medicare payments to hospital outpatient service providers[1] were correct for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during Inpatient Prospective Payment System (IPPS) stays (excluding the date of discharge).

BACKGROUND

The Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. Medicare beneficiaries are responsible for out-of-pocket costs, such as deductibles and coinsurance, for both Medicare Part A and Part B services.[2]

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

[1] Hereafter referred to as "outpatient providers." Services provided by outpatient providers do not include physician services, which are billed separately under Part B.

[2] The deductible that beneficiaries pay for Part B coverage can change yearly. Once the deductible is met, beneficiaries generally pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare in excess of the deductible. If the beneficiary also has secondary coverage under a non-Medicare health plan, the secondary payer may pay the Medicare deductible or coinsurance.

with a beneficiary's hospital stay.[3] 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.

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 before the date of admission, on the date of admission, or during the hospital stay are included in the IPPS payment (the Social Security Act (the Act) § 1886(a)(4)).

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 by an entity wholly owned or operated by the hospital) to a patient during the 3 days . . . immediately preceding the date of the patient's admission if such services are diagnostic services (including clinical diagnostic laboratory tests) or are other services related to the admission (as defined by the Secretary) . . . . [T]he term "other services related to the admission" includes all services that are not diagnostic services (other than ambulance and maintenance renal dialysis services) for which payment may be made under this title that are provided by a hospital (or an entity wholly owned or wholly operated by the hospital) to a patient -
> (A) on the date of the patient's inpatient admission; or
> (B) during the 3 days . . . immediately preceding the date of such admission unless the hospital demonstrates (in a form and manner, and at a time, specified by the Secretary) that such services are not related (as determined by the Secretary) to such admission (the Act § 1886(a)(4)).

Inpatient operating costs include, but are not limited to, operating costs for routine services (such as room, board, and 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 immediately preceding the inpatient admission (42 CFR § 412.2(c)). Preadmission services include services furnished by the hospital (or by an entity wholly owned

[3] 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.

or operated by the hospital) that are either diagnostic services furnished after January 1, 1991, or 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 §§ 412.2(c)(5)(i), (ii) and (iv)).

Payment of Nonphysician Services for Inpatients

All items and nonphysician services furnished to inpatients must be furnished directly by the hospital or billed through the hospital under arrangements (42 CFR §§ 412.50(a) and (c)). This provision applies to all hospitals, regardless of whether they are subject to PPS *(The Medicare Claims Processing Manual* (Claims Manual), chapter 3, § 10.4). Medicare does not pay any provider other than the inpatient hospital for services provided to the beneficiary while the beneficiary is an inpatient of the hospital (42 CFR § 412.50(b)).

The 60-Day Rule and 6-Year Lookback Period

OIG believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[4]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claim determinations, submit amended cost reports, or use any other appropriate reporting process.[5]

Medicare Administrative Contractors

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

[4] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; 81 Fed. Reg. 7654 (Feb. 12, 2016).

[5] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, *Provider Reimbursement Manual*—Part 1, Pub. No. 15-1, § 2931.2; 81 Fed. Reg. at 7670.

Prepayment and Postpayment Edits in the Medicare Claim Processing System

Before payment, all MAC claims are sent to CMS's Common Working File (CWF) for verification, validation, and payment authorization. The CWF contains both prepayment and postpayment system edits that should prevent or detect overpayments for outpatient services provided within 3 days before the date of admission, on the date of admission, or during inpatient stays. Once the CWF has processed a claim for payment, it electronically transmits information to the MAC about potential errors on the claim. The system edits should work as follows:

- **Prepayment Edit—**If the inpatient claim is processed for payment before the outpatient claim, once the outpatient claim is processed, a prepayment edit should deny the outpatient claim.

- **Postpayment Edit—**If the outpatient claim is processed for payment before the inpatient claim, once the inpatient claim is processed, a postpayment edit is designed to generate an "alert" to the MAC that processed the outpatient claim so that the payment can be recovered. The MAC is responsible for recovering the overpayment.

As a result of our prior audit,[6] CMS revised Medicare Learning Network, MLN Matters Number SE17033, *Medicare Does Not Pay Acute-Care Hospitals for Outpatient Services They Provide to Beneficiaries in a Covered Part A Inpatient Stay at Other Facilities,* which served to remind hospitals of proper billing of services for beneficiaries in a covered Part A inpatient stay. CMS also initiated Change Request 9813,[7] implemented on April 3, 2017, which modified the CWF prepayment edit to prevent overpayments to acute-care hospitals for outpatient services provided to Medicare beneficiaries who were inpatients of facilities other than acute-care hospitals. However, this modification did not prevent overpayments to other providers for outpatient services provided to Medicare beneficiaries who were inpatients at hospitals and, according to CMS, further refinements are necessary.

HOW WE CONDUCTED THIS AUDIT

Our audit covered 40,984 nonphysician outpatient provider services with service dates within 3 days before the date of admission, on the date of admission, or during (excluding date of discharge) IPPS stays and valued at $11.7 million[8] for calendar years (CYs) 2016 and 2017.[9] To

[6] *Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities* (A-09-16-02026), issued September 18, 2017. This report is available at https://oig.hhs.gov/oas/reports/region9/91602026.asp.

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

[8] Actual value is $11,707,874 in incorrect payments.

[9] This was the most recent claim data available at the time the audit started.

identify these services, we first identified inpatient claims from hospitals nation-wide with service dates during the audit period. We used the beneficiary information and service dates from the inpatient claims to identify outpatient claims that overlapped with the identified inpatient claims for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge).

We focused only on the inappropriate Medicare Part B payments. We did not verify whether the hospitals paid the providers that provided the outpatient services under arrangements or included the outpatient services on their Medicare Part A claims. We did not use medical review to determine whether the services were medically necessary.

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 audit scope and methodology.

FINDING

Medicare made incorrect payments to outpatient providers for 40,984 nonphysician outpatient services provided nation-wide within 3 days before the date of the inpatient admission, on the date of inpatient admission, or during IPPS stays (excluding date of discharge). These incorrect payments occurred because the CWF edits were not designed to identify all potentially incorrect claims.

As a result, Medicare made $11.7 million in incorrect payments to outpatient providers during CYs 2016 and 2017. This includes claims beyond the 4-year reopening period.[10] In addition, beneficiaries incurred $2.7 million in coinsurance and deductible liabilities[11] related to these incorrect payments.

[10] See 42 CFR § 405.980(b)(2) (permitting a contractor to reopen an initial determination within 4 years for good cause) and 42 CFR § 405.980(c)(2) (permitting a provider to request that a contractor reopen within 4 years for good cause). Notwithstanding, a provider can request that a contractor reopen an initial determination for the purpose of reporting and returning overpayments under the 60-day rule without being limited by the 4-year reopening period (42 CFR § 405.980(c)(4)).

[11] Actual value is $2,785,607 in coinsurance and deductible liabilities.

FEDERAL REQUIREMENTS

Medicare requirements state that most nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during hospital stays must be included in the IPPS payment (the Act § 1886(a)(4); 42 CFR § 412.2(c)(5)). Medicare has some exceptions to these requirements (42 CFR §§ 412.2(c)(5)(i), (ii), and (iv)).[12] Appendix A contains the details of how we accounted for these exceptions in our data match.

Beneficiaries generally share in the cost of Medicare Part B by paying deductibles and coinsurance (42 CFR § 489.30(b)). The deductible that beneficiaries pay for Part B coverage can change yearly. Once the deductible is met, beneficiaries generally pay a coinsurance amount equal to 20 percent of the amount allowed by Medicare in excess of the deductible (42 CFR § 489.30(b)). Prompt refund of deductible and coinsurance amounts incorrectly collected from beneficiaries or from someone on their behalf is the preferred method of handling incorrect collections (42 CFR § 489.41(a); Claims Manual, chapter 1, § 30.1.2).

MEDICARE ADMINISTRATIVE CONTRACTORS INCORRECTLY PAID FOR OUTPATIENT SERVICES

MACs incorrectly paid for all 40,984 outpatient services that we reviewed. The incorrectly paid outpatient services were provided nation-wide within 3 days before the date of admission, on the date of admission, or during IPPS stays (excluding date of discharge). This resulted in overpayments to providers totaling $11.7 million and $2.7 million in deductible and coinsurance amounts that were incorrectly collected from beneficiaries or from another payer on their behalf.

CMS attributed the incorrect payments of outpatient services to the CWF edits not including all the necessary information to accurately identify potentially improper claims.

Medicare paid outpatient providers for various services that either should have been furnished directly by the hospital or billed through the hospital under arrangements. These services included surgical procedures, various medicine services and procedures, evaluation and management (E&M) services, radiology and laboratory services, injections, and orthotics and prosthetic services (Figure 1 and the table on the next page).

[12] Claims Manual, chapter 3, § 10.4. There are some exceptions to this provision, including certain services payable only under Medicare Part B *(Medicare Benefit Policy Manual* (Benefit Manual), chapter 15, § 250) as well as some additional services that may be paid under part B for beneficiaries who do not have Medicare Part A benefits or have exhausted their Part A benefits (Benefit Manual, chapter 6, § 10.2). We excluded from our audit Part B only claims and claims for beneficiaries who did not have Part A benefits or had exhausted their Part A benefits.

Figure 1: Percentage of Total Payments by Type of Outpatient Service

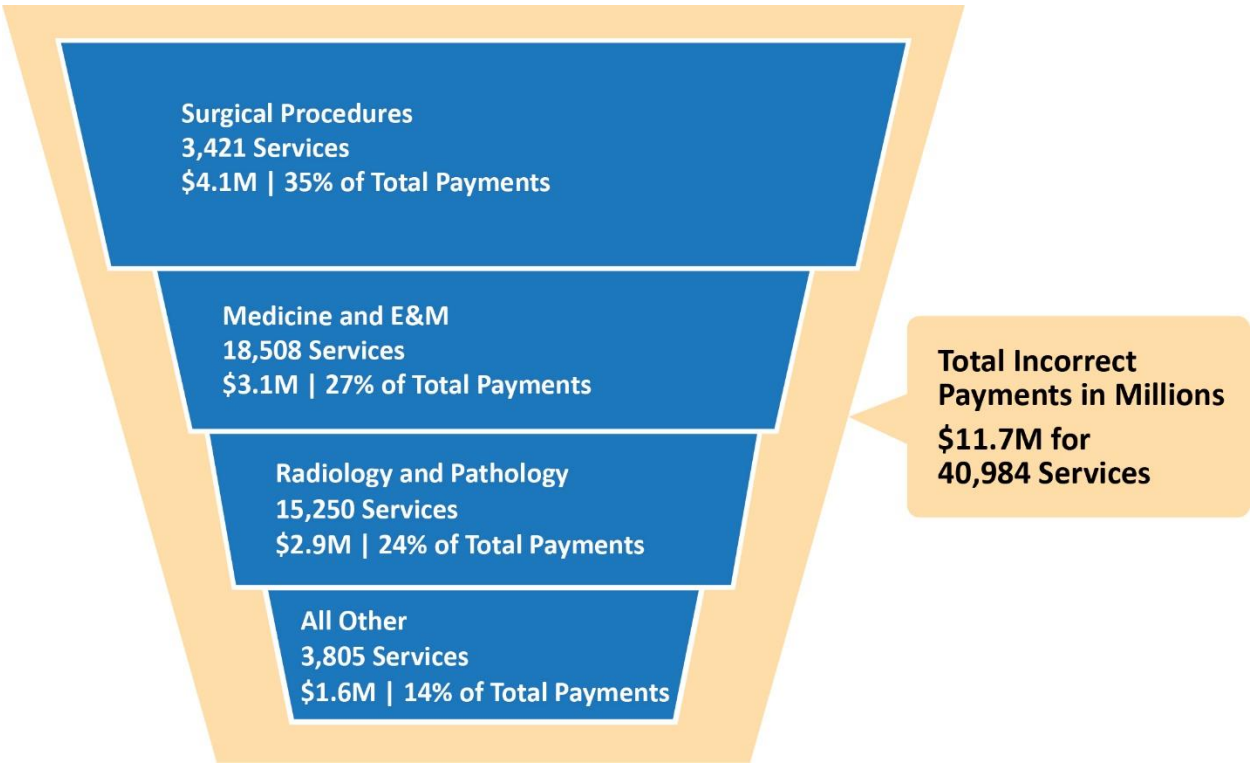


Table: Total Payments by Service Date Type

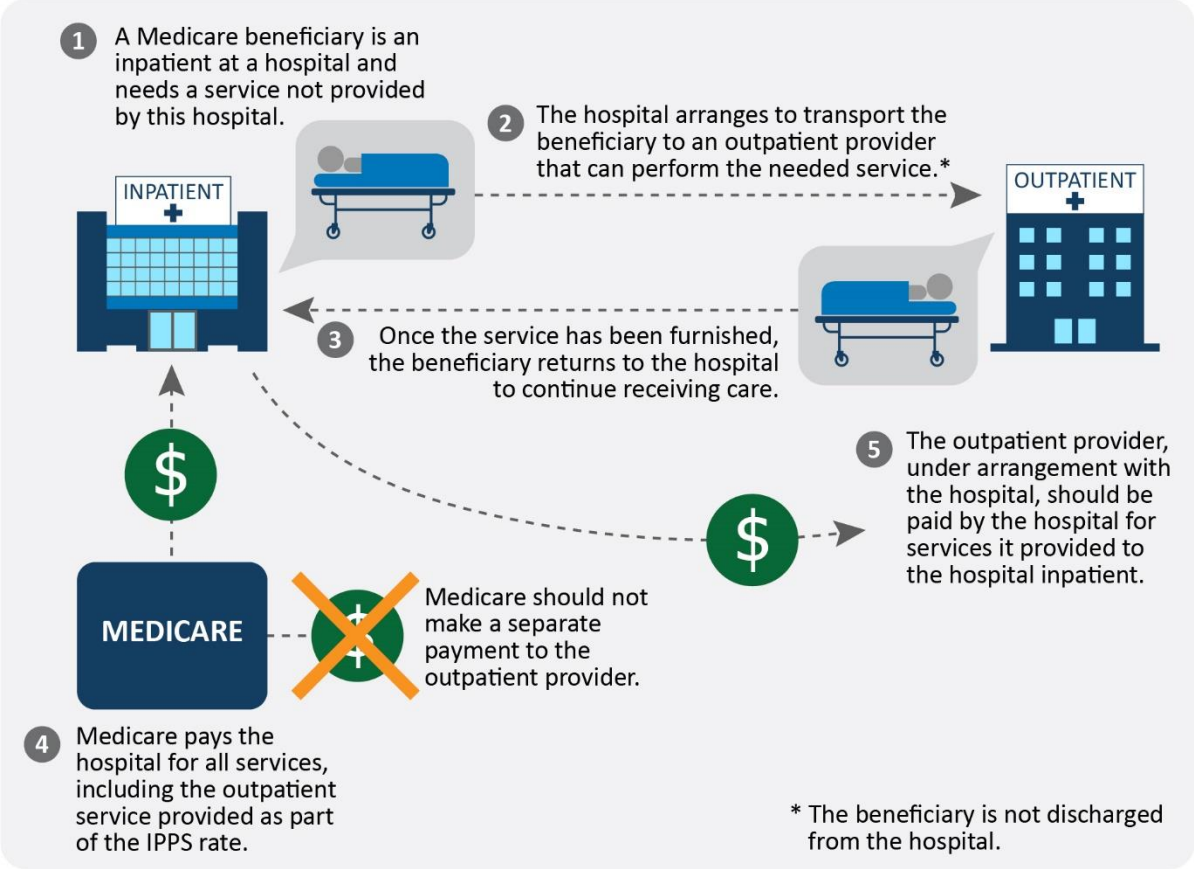
Service Date Type	# of Services Provided	% of Total Services Provided	Payment Amount	% of Total Payment
Prior to admission	2,981	7%	$568,969	5%
On date of admission	12,687	31%	3,122,495	27%
During an inpatient stay	25,320	62%	8,016,698	68%
Totals*	**40,984**	**100%**	**$11,707,874**	**100%**

*The totals in these columns do not equal the sum of the values in the columns because some outpatient services can be found in multiple service date types.

Figure 2 on the next page illustrates a situation in which a Medicare beneficiary is an inpatient at a hospital and needs a service that is not available at the hospital but can be performed on an outpatient basis by another outpatient provider. The hospital transports the beneficiary to the outpatient provider and arranges for that provider to furnish the service (the beneficiary is not discharged from the hospital). Once the service has been furnished, the beneficiary returns to the hospital to continue receiving care. Medicare pays the hospital for all services, including the outpatient service provided to the beneficiary as part of its IPPS rate. Medicare should not make a separate payment to the outpatient provider for that service. Instead, the outpatient

provider, under arrangement with the hospital, can bill the hospital for payment of the service it provided to the hospital inpatient.

Figure 2: A Beneficiary Receives a Service at an Outpatient Provider Location While Still an Inpatient at a Hospital



RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- ensure that all necessary information is included in the CWF edits to accurately identify and prevent incorrect payments for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays and

- direct the MACs to:

  - recover the portion of $11,707,874 in identified overpayments (for claims within the 4-year reopening period) resulting from the 40,984 incorrectly billed services;

- instruct the outpatient providers to refund the portion of the $2,785,607 in deductible and coinsurance amounts (for claims within the 4-year reopening period) that may have been incorrectly collected from beneficiaries or from someone on their behalf;

- based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and

- educate outpatient providers on how to correctly bill nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described the actions that it had taken or planned to take to address them. For example, CMS stated that it is currently in the process of updating the automated system edits to accurately identify and prevent incorrect payments for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during inpatient hospital stays. CMS's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 40,984 nonphysician outpatient services with service dates within 3 days before the admission, on the date of admission, or during IPPS stays (excluding date of discharge) and valued at $11,707,874 for CYs 2016 and 2017. We used the beneficiary information and service dates from the inpatient claims to identify outpatient claims from providers that corresponded with the identified inpatient claims, for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during (excluding date of discharge) an IPPS stay.

We focused only on the inappropriate Medicare Part B payments. We did not verify whether the hospitals paid the providers that performed the outpatient services under arrangements or included the outpatient services on their Medicare Part A claims. We did not use medical review to determine whether the services were medically necessary.

We did not review the overall internal control structure of CMS because our objective did not require us to do so. Rather, we limited our review of CMS's internal controls to those applicable to corresponding inpatient and outpatient claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file, but we did not assess the completeness of the file.

We conducted our audit work from November 2018 through August 2019.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's NCH file to identify Medicare Part A inpatient claims from hospitals;
- excluded claims for beneficiaries who had exhausted their Medicare Part A benefits or did not have Part A benefits;
- used CMS's NCH file to identify Medicare Part B outpatient claims from hospital providers that corresponded with the identified inpatient claims for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during (excluding date of discharge) IPPS stays;

- used CMS's Integrated Data Repository (IDR) to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;[13]

- reviewed claim histories from the CWF as necessary and excluded from our match:

    - outpatient services provided during a noncovered portion of an inpatient stay,

    - certain ambulance services,

    - outpatient preventive services,[14] and

    - outpatient services provided before or during the inpatient stay where condition code 51 was used to indicate the service was unrelated to the stay;[15]

- identified 40,984 outpatient services that should have been included on the inpatient facilities' Medicare Part A inpatient claims;

- contacted CMS to:

    - obtain an understanding of the billing requirements and edits in place in the CWF and

    - submit examples of outpatient service overpayments processed after the most recent edit implementation date, to determine the cause of overpayments;

- provided to CMS our complete list of inappropriately paid outpatient services during our audit period; and

- discussed the results of our audit with CMS officials.

[13] The IDR houses NCH data obtained from CMS. The NCH claim file is processed through a final action routine to determine the correct final version of a claim. CMS separately processes this file before placing claim data in the IDR.

[14] Examples include mammograms; Pap smears and pelvic exams; prostate, colorectal, and glaucoma screenings; influenza, pneumococcal pneumonia, and hepatitis B vaccines and their administration; and bone-mass measurements.

[15] We did not review outpatient services where condition code 51 was used prior to or during inpatient stays as this would require medical review and was outside of the scope of this audit. Condition code 51 does not apply to outpatient services provided on the date of admission. Therefore, all diagnostic and nondiagnostic services that are provided on the date of admission are related to the inpatient stay.

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 B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title*	Report Number	Issue Date
Medicare Inappropriately Paid Acute-Care Hospitals for Outpatient Services They Provided to Beneficiaries Who Were Inpatients of Other Facilities	A-09-16-02026	9/18/2017
Medicare Paid New England Providers Twice for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays	A-01-15-00511	6/28/2017
Medicare Continues To Pay Twice for Nonphysician Outpatient Services Provided Shortly Before or During an Inpatient Stay	A-01-10-00508	6/04/2012
Follow-up Audit of Improper Medicare Payments to Hospitals for Nonphysician Outpatient Services Under the Inpatient Prospective Payment System	A-01-00-00506	7/31/2001
Improper Payments to Hospitals for Nonphysician Outpatient Services under the Prospective Payment System	A-01-95-00508	5/23/1996
Expansion of the Diagnosis-Related Group Payment Window	A-01-92-00521	7/06/1994

* These reports are available at http://oig.hhs.gov.

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

Administrator
Washington, DC 20201

DATE: April 9, 2020

TO: Amy Frontz
Deputy Inspector General for Audit Services

FROM: Seema Verma
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Medicare Made $11.7 Million in Overpayments for Nonphysician Outpatient Services Provided Shortly Before or During Inpatient Stays (A-01-17-00508)

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 while protecting taxpayer dollars by preventing improper payments. Medicare paid approximately $140.5 billion for Part B outpatient services for calendar years 2016 and 2017. While OIG specifically looked at nonphysician outpatient services provided shortly before or during inpatient stays, these payments represent less than .01 percent of the overall payments made for outpatient services during this timeframe.

Inpatient hospital services provided to Medicare beneficiaries are paid under Medicare Part A. Generally, items and services furnished on an outpatient basis are paid under Medicare Part B. Section 1886(a)(4) of the Social Security Act states that the operating costs of inpatient hospital services includes the cost of all services for which payment may be made that are provided by the hospital, or by an entity wholly owned or operated by the hospital, to the patient during the three days immediately preceding the date of the patient's admission if such services are diagnostic services or are other services related to the admission. This includes all services that are not diagnostic services, other than ambulance and maintenance renal dialysis services, for which payment may be made that are provided by a hospital or entity wholly owned or operated by the hospital to a patient on the date of the patient's inpatient admission or during the three days immediately preceding the date of such admission unless the hospital demonstrates that such services are not related to such admission. Federal regulation also states that Medicare does not pay any provider other than the inpatient hospital for services provided to a beneficiary while a beneficiary is an inpatient of the hospital. Therefore, all items and nonphysician services provided immediately before and during a Part A inpatient stay must be provided directly by the inpatient hospital or under arrangements with another provider and billed to Medicare by the inpatient hospital through its Part A claim. When a provider incorrectly bills for an item or service under Part B, the beneficiary or someone on their behalf may be subject to deductible or coinsurance charges. Medicare providers should refund any deductible or coinsurance amount that was incorrectly collected from a beneficiary or someone on their behalf.

CMS has taken actions to prevent Medicare overpayments by educating providers on proper billing, specifically in situations where items and services should be covered by Part A. CMS

educates providers on avoiding Medicare billing errors through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. Additionally, CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system, and conducting prepayment and postpayment reviews. CMS is currently in the process of updating the automated system edits to accurately identify and prevent incorrect payments for nonphysician outpatient services provided within three days before the date of admission, on the date of admission, or during inpatient hospital stays.

OIG's recommendations and CMS' responses are below.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services ensure that all necessary information is included in the CWF edits to accurately identify and prevent incorrect payments for nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays.

CMS Response

CMS concurs with this recommendation. As stated above, CMS is in the process of modifying the common working file edits to accurately identify and prevent incorrect payments for nonphysician outpatient services provided within three days before the date of admission, on the date of admission, or during IPPS stays. These changes are scheduled to take effect summer 2020.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to recover the portion of $11,707,874 in identified overpayments (for claims within the 4-year reopening period) resulting from the 40,984 incorrectly billed services.

CMS Response

CMS concurs with this recommendation. CMS will direct its Medicare Administrative Contractors to recover the identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to instruct the outpatient providers to refund the portion of the $2,785,607 in deductible and coinsurance amounts (for claims within the 4-year reopening period) that may have been incorrectly collected from beneficiaries or from someone on their behalf.

CMS Response

CMS concurs with this recommendation. Providers are required to refund any deductible or coinsurance amounts that are related to claims that are determined to be overpayments. As part of the recovery process, the Medicare Administrative Contractors will instruct providers to refund any deductible or coinsurance amounts that may have been incorrectly collected from beneficiaries or from someone on their behalf.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to based upon the results of this audit, notify appropriate providers (i.e., those for whom CMS determines this audit constitutes credible information of potential overpayments) so that the providers can exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation.

CMS Response

CMS concurs with this recommendation. CMS will analyze the OIG's data to identify appropriate providers to notify of potential overpayments. Within CMS's policies and procedures, CMS will then instruct its Medicare Contractors to notify the identified providers of OIG's audit findings. CMS will track any returned overpayments made in accordance with this recommendation and the 60-day rule.

OIG Recommendation

The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to educate outpatient providers on how to correctly bill nonphysician outpatient services provided within 3 days before the date of admission, on the date of admission, or during IPPS stays.

CMS Response

CMS concurs with this recommendation. CMS will work with its Medicare Administrative Contractors to continue to educate providers on how to correctly bill nonphysician outpatient services provided within three days before the date of admission, on the date of admission, or during IPPS stays.