



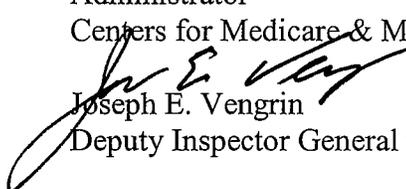
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

AUG 24 2006

**TO:** Mark B. McClellan, M.D., Ph.D.  
Administrator  
Centers for Medicare & Medicaid Services

**FROM:**   
Joseph E. Vengrin  
Deputy Inspector General for Audit Services

**SUBJECT:** Medicare Part B Payments for Radiology Services Provided During  
Inpatient Stays: 2001 Through 2003 (A-01-04-00528)

The attached final report provides the results of our review of Medicare Part B payments for radiology services provided during inpatient stays. The objective of our review was to determine whether carriers made inappropriate Part B payments for outpatient radiology services provided to Medicare beneficiaries during inpatient stays at prospective payment system (PPS) hospitals.

Under the PPS for acute care hospitals, suppliers that render nonphysician Part B services during inpatient stays are required to bill the hospitals, not the Medicare carriers, for those services. Carriers are responsible for ensuring that they do not pay for nonphysician services provided to hospital inpatients.

During calendar years 2001–2003, carriers inappropriately made Part B payments for 100,034 outpatient radiology services provided to PPS hospital inpatients. Rather than billing the hospitals for these services, radiology suppliers billed the carriers and received separate payments. As a result, Medicare overpaid an estimated \$20 million for radiology services by paying twice: once to the hospital as part of the prospective payment and again to the radiology supplier under Part B. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid approximately \$5.7 million in coinsurance and deductibles related to these potential overpayments.

Neither the Centers for Medicare & Medicaid Services (CMS) nor its carriers had established computerized edits to detect and prevent these Part B payments. In addition, CMS officials advised us that CMS had no postpayment review procedures for identifying Part B payments for outpatient radiology services provided to hospital inpatients that duplicated a portion of the prospective payments.

We recommend that CMS:

- instruct the Medicare carriers to recover the \$20 million in potential overpayments identified in our review and monitor the recovery of those overpayments,

- establish prepayment controls to detect and prevent separate payments for Medicare Part B radiology services provided to beneficiaries during inpatient stays in PPS hospitals and/or develop postpayment review procedures to identify suppliers that submit and receive payments for inappropriate billings, and
- alert the Medicare carriers to the most common types of payment errors and help them educate radiology suppliers about such improper billings.

In its comments on the draft report, CMS generally agreed with our recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov). Please refer to report number A-01-04-00528 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PART B PAYMENTS  
FOR RADIOLOGY SERVICES  
PROVIDED DURING  
INPATIENT STAYS:  
2001 THROUGH 2003**



Daniel R. Levinson  
Inspector General

August 2006  
A-01-04-00528

# *Office of Inspector General*

<http://oig.hhs.gov>

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



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Under Medicare's inpatient prospective payment system (PPS), fiscal intermediaries reimburse acute care hospitals a predetermined amount for services furnished to Medicare beneficiaries based on their illness and its classification under a diagnosis-related group (DRG). The DRG payment for inpatient services covers nonphysician outpatient services that Medicare beneficiaries receive during an inpatient stay. These nonphysician outpatient services include radiology services, such as tomography scans, furnished to inpatients by a physician's office, another hospital, or a radiology clinic. Accordingly, radiology suppliers that render nonphysician outpatient services during inpatient stays are required to bill the PPS hospitals, not the Medicare carriers, for those services. In addition, carriers are responsible for ensuring that they do not pay for nonphysician radiology services provided to hospital inpatients.

This audit follows up on a prior review of nonphysician services provided to Medicare beneficiaries during inpatient stays at PPS hospitals in calendar years 1998–2000.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) generally agreed with that report's recommendations to recover inappropriate payments and establish procedures to preclude such payments.

### **OBJECTIVE**

The objective of our audit was to determine whether carriers made inappropriate Part B payments for outpatient radiology services provided to Medicare beneficiaries during inpatient stays at PPS hospitals.

### **SUMMARY OF FINDING**

During calendar years 2001–2003, carriers inappropriately made Part B payments for 100,034 outpatient radiology services provided to PPS hospital inpatients. Rather than billing the hospitals for these services, radiology suppliers billed the carriers and received separate payments. As a result, Medicare overpaid an estimated \$20 million for radiology services by paying twice: once to the hospital as part of the DRG payment and again to the radiology supplier under Part B. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid approximately \$5.7 million in coinsurance and deductibles related to these potential overpayments.

Neither CMS nor its carriers had established computerized edits to detect and prevent these Part B payments. In addition, CMS and the carriers had no postpayment review procedures for identifying Part B payments for outpatient radiology services provided to hospital inpatients that duplicated a portion of the DRG payments.

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<sup>1</sup>“Nationwide Review of Compliance With Medicare Billing Rules for Ambulance and Radiology Services Rendered by an Independent Entity During an Inpatient Hospital Stay” (A-01-01-00502, issued August 6, 2002).

## **RECOMMENDATIONS**

We recommend that CMS:

- instruct the Medicare carriers to recover the \$20 million in potential overpayments identified in our review and monitor the recovery of those overpayments,
- establish prepayment controls to detect and prevent separate payments for Medicare Part B radiology services provided to beneficiaries during inpatient stays in PPS hospitals and/or develop postpayment review procedures to identify suppliers that submit and receive payments for inappropriate billings, and
- alert the Medicare carriers to the most common types of payment errors and help them educate radiology suppliers about such improper billings.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its comments on the draft report, CMS generally agreed with our recommendations. CMS's comments are included in their entirety as Appendix C.

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## INTRODUCTION

### BACKGROUND

#### **Inpatient Prospective Payment System**

Section 1886(d) of the Social Security Act established a prospective payment system (PPS) for inpatient services furnished to Medicare beneficiaries by acute care hospitals for cost-reporting periods beginning on or after October 1, 1983. Under the PPS, Medicare fiscal intermediaries reimburse hospitals a predetermined amount for services based on a beneficiary's illness and its classification under a diagnosis-related group (DRG). The DRG payment for inpatient services covers nonphysician outpatient services, such as radiology services, that the beneficiary receives during an inpatient stay.

Outpatient radiology services, such as tomography scans, can be furnished to inpatients in a physician's office, another hospital, or a radiology clinic. These services include both professional (physician) and technical (nonphysician) components. The professional component relates to the physician's interpretation of the radiology test results. The technical component relates to the equipment and the technician's performance of the tests.

The professional component of outpatient radiology services is not covered by the DRG and should be billed (using a modifier) to and paid by the Medicare Part B carrier. However, the technical component of outpatient radiology services provided to hospital inpatients is covered by the DRG. Accordingly, radiology suppliers that provide outpatient services to Medicare beneficiaries during inpatient stays are required to bill the PPS hospital, not the carrier, for the technical component of those services. In addition, carriers are responsible for ensuring that they do not pay for nonphysician services, such as the technical component of radiology services provided to hospital inpatients.

#### **Prior Review**

This audit follows up on a prior review of nonphysician services provided to Medicare beneficiaries during inpatient stays at PPS hospitals in calendar years (CYs) 1998–2000.<sup>1</sup> The Centers for Medicare & Medicaid Services (CMS) generally agreed with that report's recommendations to recover inappropriate payments and establish procedures to preclude such payments.

### OBJECTIVE, SCOPE, AND METHODOLOGY

#### **Objective**

The objective of our audit was to determine whether carriers made inappropriate Part B payments for outpatient radiology services provided to Medicare beneficiaries during inpatient stays at PPS hospitals.

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<sup>1</sup>“Nationwide Review of Compliance With Medicare Billing Rules for Ambulance and Radiology Services Rendered by an Independent Entity During an Inpatient Hospital Stay” (A-01-01-00502, issued August 6, 2002).

## Scope

Our audit covered the period January 1, 2001, through December 31, 2003. We limited consideration of the internal control structure to CMS's Common Working File and selected Medicare carriers' Part B claims processing systems. Our objective did not require an understanding or assessment of the complete internal control structure of CMS or its contractors. Also, we did not assess the completeness of the file extracted from CMS's National Claims History File.

We conducted our review from March 2005 to February 2006.

## Methodology

To accomplish our objectives, we:

- reviewed applicable Medicare requirements;
- performed a nationwide computer match (using CMS's National Claims History File) to identify Medicare Part B payments during CYs 2001–2003 for services designated as outpatient radiology services (that included technical components) provided to Medicare beneficiaries during inpatient stays at PPS hospitals, excluding the days of admission and discharge;
- randomly selected a sample of 50 beneficiary days for each of the 3 CYs from a total of 48,045 beneficiary days, during which 100,034 Part B radiology services were provided to hospital inpatients;<sup>2</sup>
- verified admission and discharge dates for the sampled claims with hospitals to ensure that no leaves of absence had disrupted the inpatient stays;
- contacted 141 Part B radiology suppliers to determine why the suppliers had billed the Medicare carriers instead of the hospitals for the technical component of radiology services provided to hospital inpatients;
- contacted 12 of the Medicare carriers involved in the 150 sampled beneficiary days to determine whether their computer systems had edits that would detect and prevent Part B payments for the technical component of radiology services provided to Medicare beneficiaries who were hospital inpatients;
- contacted CMS officials to follow up on the status of actions taken on the recommendations made in our prior review; and
- discussed the results of our review with CMS central office officials.

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<sup>2</sup>A beneficiary day represents all radiology services provided to a beneficiary on a date of service.

We conducted our review in accordance with generally accepted government auditing standards.

## **FINDING AND RECOMMENDATIONS**

During the 3-year audit period, carriers inappropriately made Part B payments for the technical component of many outpatient radiology services provided to PPS hospital inpatients. Rather than billing the hospitals for these services, radiology suppliers billed the carriers and received separate payments. As a result, Medicare overpaid an estimated \$20 million for radiology services by paying for the technical component twice: once to the hospital as part of the DRG payment and again to the radiology supplier under Part B. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid approximately \$5.7 million in coinsurance and deductibles related to these potential Medicare overpayments.

Neither CMS nor its carriers had established computerized edits to detect and prevent these inappropriate Part B payments. In addition, CMS and the carriers had no postpayment review procedures for identifying Part B payments for outpatient radiology services provided to hospital inpatients that duplicated a portion of the DRG payments.

## **PROGRAM REQUIREMENTS**

The “Medicare Claims Processing Manual,” Publication 100-04, Chapter 13, sections 20.1 and 20.2.1, states in part that in all settings, the professional component of radiology services provided by a physician to an individual patient should be billed to and paid by the carrier. However, suppliers that provide the technical component of radiology services to hospital inpatients are required to bill the PPS hospital, not the Medicare carrier, for those services. The technical component of radiology services furnished to hospital inpatients is covered as a hospital service under Part A, and carriers are responsible for ensuring that they do not pay for these services. In addition, the “Medicare Claims Processing Manual,” Chapter 26, provides instructions for completing the Form CMS-1500, which requires the provider to certify that information on the claim is true, accurate, and complete.

## **ADHERENCE TO PROGRAM REQUIREMENTS**

Our nationwide computer match for CYs 2001–2003 identified a significant number of potentially overpaid claims for radiology services that were provided to Medicare beneficiaries during inpatient stays in PPS hospitals. We identified 100,034 radiology services within 48,045 beneficiary days that may have been inappropriately paid. We limited our population to beneficiary days for which the Medicare payment totaled at least \$100.

To verify that our computer match was valid, we randomly selected a sample of all radiology services provided for 50 beneficiary days in each of the 3 CYs, for which Medicare payments totaled \$74,529. Our review of the sampled items disclosed that carriers had incorrectly paid for radiology services totaling \$62,766. Accordingly, we believe that most of the amounts that our computer match identified were submitted in error by radiology suppliers and incorrectly paid by carriers. Extrapolating these results to the population, we estimated that carriers overpaid

radiology suppliers by \$20 million. Details of the sampling methodology, results, and projections are in Appendixes A and B.

A limited number of suppliers were responsible for a large share of the radiology services that were potentially overpaid. Specifically, one-third of the radiology suppliers in our population accounted for approximately 87 percent of these services, as the following table shows:

**Distribution of Services That Were Potentially Overpaid**

	<b>Suppliers</b>		<b>Services That Were Potentially Overpaid</b>	
	<b>Number</b>	<b>Percentage of Total Suppliers</b>	<b>Number</b>	<b>Percentage of Total Services</b>
One-third of suppliers	3,242	33.34%	87,440	87.41%
Remainder	6,481	66.66%	12,594	12.59%
<b>Total</b>	<b>9,723</b>	<b>100.00%</b>	<b>100,034</b>	<b>100.00%</b>

**NEED FOR STRONGER INTERNAL CONTROLS**

**Centers for Medicare & Medicaid Services**

In our earlier report (A-01-01-00502, issued August 6, 2002), we recommended that CMS (1) establish payment controls to detect and prevent separate payments for Medicare Part B nonphysician services provided to Medicare beneficiaries during inpatient stays in PPS hospitals and/or (2) develop computer applications to identify providers who frequently submit and receive payments for inappropriate billings. We also recommended that CMS alert Medicare carriers to the most common types of payment errors and direct them to educate their suppliers about such improper billings. Although CMS agreed with these recommendations, it had not implemented them by the end of February 2006.

**Carriers**

The 12 Medicare carriers that we contacted did not have adequate controls to detect and prevent improper payments for radiology services provided to hospital inpatients. However, most of the carriers indicated that they had provided education, training, and workshops to radiology suppliers on the proper billing procedures for services provided to Medicare beneficiaries during inpatient stays.

**Radiology Suppliers**

We used our randomly selected sample to validate our computer match and to determine why radiology suppliers billed the carriers instead of the hospitals. We found the following:

- For 70 of the 150 sampled items, radiology supplier officials:
  - were not aware of the Medicare program requirements related to billing for radiology services provided to hospital inpatients (23 sampled items),
  - billed incorrectly because of human error (22 sampled items),
  - billed incorrectly with no specific reason given (15 sampled items), or
  - did not know that the beneficiary was an inpatient at the time the radiology services were provided (10 sampled items).
- For 5 of the 150 sampled items, the supplier billed the wrong date of service. Our computer match identified these payments as inappropriate because the supplier submitted incorrect information.<sup>3</sup>
- For 4 of the 150 sampled items, the supplier billed using incomplete information. Our computer match identified these payments as inappropriate because the supplier did not include the modifier to indicate that the claim was for only the professional component of the service.<sup>3</sup>
- For the remaining 71 of the 150 sampled items, suppliers did not respond or did not dispute the results of our computer match.

If CMS had implemented appropriate edits, the carriers would not have paid most of these 150 sampled items.

## **POTENTIAL OVERPAYMENTS FOR RADIOLOGY SERVICES**

Our review identified 48,045 Medicare Part B beneficiary days containing 100,034 radiology services estimated at more than \$20 million that Medicare carriers potentially should not have paid. Furthermore, the Medicaid program (for individuals eligible for both Medicare and Medicaid), beneficiaries, or their supplemental insurers could have paid approximately \$5.7 million in coinsurance and deductibles related to these potential Medicare overpayments.

## **RECOMMENDATIONS**

We recommend that CMS:

- instruct the Medicare carriers to recover the \$20 million in potential overpayments identified in our review and monitor the recovery of those overpayments,

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<sup>3</sup>We acknowledge that some of these sampled items might be reimbursable under Part B if the radiology suppliers resubmit the claims after the erroneous date of service is corrected or the modifier is included.

- establish prepayment controls to detect and prevent separate payments for Medicare Part B radiology services provided to beneficiaries during inpatient stays in PPS hospitals and/or develop postpayment review procedures to identify suppliers that submit and receive payments for inappropriate billings, and
- alert the Medicare carriers to the most common types of payment errors and help them educate radiology suppliers about such improper billings.

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS**

In its August 4, 2006, comments on the draft report, CMS generally agreed with our recommendations and stated that it planned to recover the overpayments identified consistent with CMS's policies and procedures. CMS requested that we provide the data necessary to initiate and complete recovery action. CMS's comments are included in their entirety as Appendix C.

#### **OFFICE OF INSPECTOR GENERAL RESPONSE**

We will provide the requested overpayment data.

# **APPENDIXES**

## SAMPLING METHODOLOGY

### OBJECTIVE

The objective of our audit was to determine whether carriers made inappropriate Part B payments for outpatient radiology services provided to Medicare beneficiaries during inpatient stays at prospective payment system hospitals.

### POPULATION

The population consisted of beneficiary days with Part B payments for radiology services totaling at least \$100 provided to Medicare beneficiaries during hospital inpatient stays for calendar years 2001–2003. (See the table below.)

**Population Characteristics**

<b>Stratum</b>	<b>Number of Beneficiary Days</b>	<b>Number of Services</b>	<b>Medicare Payments</b>	<b>Deductibles and Coinsurance</b>
2001	17,201	35,069	\$8,783,241	\$2,444,371
2002	15,240	31,527	7,475,867	2,136,281
2003	15,604	33,438	8,257,935	2,444,740
<b>Total</b>	<b>48,045</b>	<b>100,034</b>	<b>\$24,517,043</b>	<b>\$7,025,392</b>

### SAMPLE DESIGN

The audit used a stratified random sample consisting of three strata, one for each of calendar years 2001–2003. We determined error amounts by identifying the portion of the payment that was for the technical component of the service.

### SAMPLE SIZE

The sample consisted of 150 beneficiary days, 50 from each of the 3 strata.

## SAMPLE RESULTS AND PROJECTIONS

### SAMPLE RESULTS

The following table presents our sample results.

#### Sample Results

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
2001	50	\$22,211	48	\$18,410
2002	50	26,532	48	22,624
2003	50	25,786	50	21,732
<b>Total</b>	<b>150</b>	<b>\$74,529</b>	<b>146</b>	<b>\$62,766</b>

Note: The difference between the value of the sample (amount paid) and the value of the errors (technical component) represents payments for the professional component.

### VARIABLE PROJECTIONS

The overall point estimate of the sample was \$20,011,162, with a precision of plus or minus \$2,364,979 at the 90-percent confidence level. The individual point estimates were \$6,333,384 for 2001, \$6,895,762 for 2002, and \$6,782,016 for 2003.

To determine the approximate amount of deductibles and coinsurance related to the technical component of the procedure codes, we calculated a ratio of the point estimate to the total amount paid by Medicare. We then applied this ratio of approximately 82 percent to the total deductible and coinsurance amount of approximately \$7 million, which resulted in about \$5.7 million in coinsurance and deductibles related to these potential overpayments.



DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Centers for Medicare &amp; Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** AUG - 4 2006

**TO:** Joseph E. Vengrin  
Deputy Inspector General for Audit Services  
Office of Inspector General

**FROM:** Mark B. McClellan, M.D., Ph.D.   
Administrator

**SUBJECT:** Office of Inspector General's (OIG) Draft Report: "Medicare Part B Payments for Radiology Services Provided During Inpatient Stays: 2001 Through 2003" (A-01-04-00528)

Thank you for the opportunity to review the OIG draft report entitled "Medicare Part B Payments for Radiology Services Provided During Inpatient Stays: 2001 Through 2003."

Under the prospective payment system (PPS) for acute care hospitals, suppliers of radiology services during a beneficiary inpatient stay are required to bill the hospitals, not the Medicare carrier. OIG identified inappropriate Part B payments made by carriers for radiology services provided to PPS hospital inpatients for the calendar years 2001 through 2003. Since 1996, the Centers for Medicare & Medicaid Services (CMS) has measured improper payments through the Comprehensive Error Rate Testing Program. We have focused our corrective actions on the areas most susceptible to error. This general issue of improper payments across the Part A and Part B benefits has come to our attention in the past, and we have successfully addressed these types of errors by installing edits. In response to your recommendation, we will explore the need for edits in this specific case.

The CMS has directed the fiscal intermediaries (FIs) to conduct data analysis and, based upon their findings, conduct provider education and medical review as necessary to ensure that claims for radiology services are paid appropriately. If it is determined that there is a program vulnerability, CMS will issue a special Medical Review Vulnerability (MERV) Report to all FIs to alert them to this potential program risk.

**OIG Recommendation**

CMS should instruct the Medicare carriers to recover \$20 million in potential overpayments identified in our review and monitor the recovery of those overpayments.

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**CMS Response**

We agree that the overpayments (subject to verification by the Medicare contractors) should be recovered. The CMS plans to recover the overpayments identified consistent with the Agency's policies and procedures.

The CMS requires that the necessary overpayment data be provided by the OIG and requests that the data be provided in a format that facilitates the distribution of the overpayment data via a Joint Signature Memo. The OIG will be required to furnish for each overpayment the data necessary (provider numbers, claims information including the paid date, health insurance claim numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor specific data should be written to separate CD-ROMs in order to better facilitate the transfer of information to the appropriate contractors.

**OIG Recommendation**

CMS should establish prepayment controls to detect and prevent separate payments for Medicare Part B radiology services provided to beneficiaries during inpatient stays in PPS hospitals, and/or develop postpayment review procedures to identify suppliers that submit and receive payments for inappropriate billings.

**CMS Response**

We concur with the recommendation that CMS develop edits to prevent inappropriate payment by a carrier for radiology services provided to a beneficiary during an inpatient stay. We shall pursue Carrier claims processing procedures to deny claims for radiology services billed to a carrier when the beneficiary is an inpatient and their inpatient status is available in our Common Working File (CWF) at the time the claim is processed. In addition, we shall pursue postpayment review procedures to identify radiology services paid by a carrier when the CWF has posted an inpatient stay for the beneficiary and the carrier's recoupment of any inappropriate payment.

**OIG Recommendation**

CMS should alert the Medicare carriers to the most common types of payment errors and help them educate radiology suppliers about such improper billings.

**CMS Response**

We concur with this recommendation. Carriers shall be directed to educate radiology suppliers that services provided to an inpatient shall be billed to the hospital. In addition, CMS will prepare and send out a MERV report to alert the contractors about the information contained in

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**the OIG report. Each contractor should review the MERV report, review their data, and take appropriate action considering the CMS goal of reducing the paid claims error rate.**

**Thank you for your efforts in identifying inappropriate payments to radiology suppliers. CMS will use this information as the basis for prepayment editing and postpayment procedures.**

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