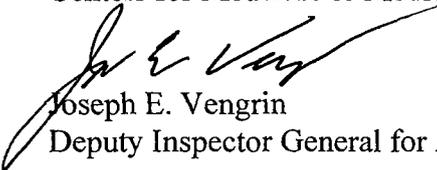




DEC - 4 2006

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Review of Place of Service Coding for Physician Services Processed by National Heritage Insurance Company During Calendar Years 2002 and 2003
(A-01-06-00502)

Attached is an advance copy of our final report on place of service coding for physician services processed by National Heritage Insurance Company (NHIC) during calendar years 2002 and 2003. We will issue this report to NHIC within 5 business days.

Medicare Part B pays for services that physicians provide to program beneficiaries. Although physicians routinely perform many of these services in an outpatient hospital department or a freestanding ambulatory surgical center, some of these services may also be performed in nonfacility settings such as a physician's office. To account for the increased expense that physicians incur by performing services in their offices, Medicare reimburses physicians a higher amount for services performed in their offices rather than in an outpatient hospital or an ambulatory surgical center.

Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare Part B carriers. The correct place of service code ensures that Medicare does not duplicate payment to the physician and the facility. NHIC is a Medicare Part B carrier that processes and pays claims submitted by Part B providers in five States.

The objective of our audit was to determine whether physicians properly coded the place of service on claims submitted to and paid by NHIC.

Physicians did not always properly code the place of service on claims submitted to and paid by NHIC. Specifically, physicians incorrectly coded the place of service on 81 of the 100 sampled claims by using the office place of service code even though they performed the services in an outpatient hospital or an ambulatory surgical center. Physicians correctly coded 19 of the 100 sampled claims.

As a result of the incorrect coding, NHIC overpaid the physicians \$5,423 for the 81 sampled claims. Based on a statistical projection, we estimate that NHIC overpaid physicians \$4,254,613 for incorrectly coded services provided during the 2-year period that ended December 31, 2003. We attribute the overpayments to internal control weaknesses at the physician billing level.

We recommend that NHIC:

- recover the \$5,423 in overpayments for the sampled services,
- review our information on the additional 122,054 services estimated at \$4,249,190 that were potentially billed with an incorrect place of service code and work with the physicians who provided the services to recover any overpayments,
- strengthen its education process and reemphasize to physicians and their billing agents the importance of correctly reporting the place of service and the need for internal control systems to prevent Medicare billings with incorrect place of service codes, and
- work with the program safeguard contractor to develop a data match that will identify physician services having a high risk for place of service miscoding and to recover resulting program overpayments.

In its comments on our draft report, NHIC generally agreed to implement our recommendations subject to (1) the 4-year reopening period specified in 42 CFR § 405.841 and (2) its analysis of data to achieve the maximum cost/recovery benefit.

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 Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2864. Please refer to report number A-01-06-00502.

Attachment



Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

DEC - 7 2006

Report Number: A-01-06-00502

Ms. Jennifer Otten
Audit and Controls Manager
National Heritage Insurance Company
402 Otterson Drive
Chico, California 95928

Dear Ms. Otten:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Place of Service Coding for Physician Services Processed by National Heritage Insurance Company During Calendar Years 2002 and 2003." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

If you have any questions or comments about this report, please do not hesitate to contact me at (617) 565-2684 or through e-mail at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-06-00502 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Jeff Flick
Regional Administrator
Department of Health and Human Services
Centers for Medicare & Medicaid Services
75 Hawthorne Street, Suite 408
San Francisco, California 94105

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF PLACE OF SERVICE
CODING FOR PHYSICIAN
SERVICES PROCESSED BY
NATIONAL HERITAGE
INSURANCE COMPANY DURING
CALENDAR YEARS
2002 AND 2003**



Daniel R. Levinson
Inspector General

December 2006
A-01-06-00502

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

OAS FINDINGS AND OPINIONS

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

Medicare Part B pays for services that physicians provide to program beneficiaries. Although physicians routinely perform many of these services in an outpatient hospital department or a freestanding ambulatory surgical center, some of these services may also be performed in nonfacility settings such as a physician's office. To account for the increased expense that physicians incur by performing services in their offices, Medicare reimburses physicians a higher amount for services performed in their offices rather than in an outpatient hospital or an ambulatory surgical center.

Physicians are required to identify the place of service on the health insurance claim forms that they submit to Medicare Part B carriers. The correct place of service code ensures that Medicare does not duplicate payment to the physician and the facility. National Heritage Insurance Company (NHIC) is a Medicare Part B carrier that processes and pays claims submitted by Part B providers in five States.

OBJECTIVE

The objective of our audit was to determine whether physicians properly coded the place of service on claims submitted to and paid by NHIC.

SUMMARY OF FINDING

Physicians did not always properly code the place of service on claims submitted to and paid by NHIC. Specifically, physicians incorrectly coded the place of service on 81 of the 100 sampled claims by using the office place of service code even though they performed the services in an outpatient hospital or an ambulatory surgical center. Physicians correctly coded 19 of the 100 sampled claims.

As a result of the incorrect coding, NHIC overpaid the physicians \$5,423 for the 81 sampled claims. Based on a statistical projection, we estimate that NHIC overpaid physicians \$4,254,613 for incorrectly coded services provided during the 2-year period that ended December 31, 2003. We attribute the overpayments to internal control weaknesses at the physician billing level.

RECOMMENDATIONS

We recommend that NHIC:

- recover the \$5,423 in overpayments for the sampled services,
- review our information on the additional 122,054 services estimated at \$4,249,190 that were potentially billed with an incorrect place of service code and work with the physicians who provided the services to recover any overpayments,

- strengthen its education process and reemphasize to physicians and their billing agents the importance of correctly reporting the place of service and the need for internal control systems to prevent Medicare billings with incorrect place of service codes, and
- work with the program safeguard contractor to develop a data match that will identify physician services having a high risk for place of service miscoding and to recover resulting program overpayments.

AUDITEE'S COMMENTS

In its comments on our draft report, NHIC generally agreed to implement our recommendations subject to (1) the 4-year reopening period specified in 42 CFR § 405.841 and (2) its analysis of data to achieve the maximum cost/recovery benefit. We have included NHIC's comments in their entirety as Appendix D.

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INTRODUCTION

BACKGROUND

Medicare Part B Procedures and Services

Medicare Part B pays for services that physicians provide to program beneficiaries. Physician services include medical and surgical procedures, office visits, and medical consultations. These services are provided in different facility and nonfacility settings, including outpatient hospital departments, freestanding ambulatory surgical centers (ASC), and physician offices.

Medicare Payment for Physician Services

Physicians are paid for services according to the Medicare physician fee schedule. This schedule is based on a payment system that includes three major categories of costs required to provide physician services: practice expense, physician work, and malpractice insurance. Practice expense reflects the overhead costs involved in providing a service.

To account for the increased practice expense that physicians incur by performing services in their offices, Medicare reimburses physicians a higher amount for services performed in their offices rather than in an outpatient hospital or an ASC. Physicians are required to identify the place of service by using codes on the health insurance claim forms that they submit to Medicare Part B carriers. The correct place of service code ensures that Medicare does not duplicate payment to the physician and the facility.

Medicare claim form instructions specifically state that each provider or practitioner is responsible for becoming familiar with Medicare coverage and billing requirements. Some physician offices submit their own claims to Medicare carriers; other offices hire billing services to submit their claims. Physicians are responsible for any Medicare payments generated from claims submitted by billing services.

Carrier Responsibility

The Medicare Part B carriers, under contract with the Centers for Medicare & Medicaid Services (CMS), process and pay claims submitted by physicians, clinical laboratories, suppliers, and ASCs. National Heritage Insurance Company (NHIC) is the Medicare Part B carrier that processes and pays claims submitted by Part B providers in Massachusetts, Maine, New Hampshire, Vermont, and California.

Prior Office of Inspector General Reports

Our previous reviews at several carriers found that carriers overpaid physicians who did not correctly identify the place of service on their billings. (See Appendix A.) Our recommendations in those reports called for CMS's carriers to educate physicians regarding proper billing, recover identified overpayments, and analyze postpayment data to detect and

recover overpayments for improperly billed claims. The carriers generally concurred with our recommendations.¹

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of our audit was to determine whether physicians properly coded the place of service on claims submitted to and paid by NHIC.

Scope

Our audit covered physician services provided from January 1, 2002, through December 31, 2003. We analyzed a stratified sample of 100 services selected from a population of 122,154 physician services that NHIC had paid and that our computer match had identified as having a high risk for error. (See Appendix B.)

The objective of our audit did not require an understanding or assessment of the complete internal control structure at NHIC or the physicians' offices. Therefore, we limited our review of internal controls at NHIC to the payment controls in place to prevent program overpayments resulting from place of service billing errors. We limited our review of internal controls at physicians' offices to obtaining an understanding of controls related to developing and submitting Medicare claims.

We performed our review from February through July 2006. Our fieldwork included contacting 85 physicians by mail, telephone, and, in some instances, site visits. We also performed fieldwork at NHIC in Hingham, Massachusetts.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- identified services coded as being performed in a physician's office that were at high risk for overpayment because the coding would result in higher payment to the physician;
- matched claims from physicians for services at high risk for overpayment to claims from outpatient hospitals or ASCs for the same service performed for the same beneficiary on the same date;
- selected a stratified random sample of 100 paid services from our computer match, which identified services that had a high risk of payment error;

¹On July 23, 2003, we issued a final report to NHIC (report number A-01-02-00524) on physician place of service miscoding of ambulatory surgical services.

- reviewed Common Working File and paid claims data for the sampled services to validate the amounts of payments to physicians and to determine the place of service for which the services were paid;
- sent a detailed internal control questionnaire and request for medical and billing records to 85 physicians who provided the sampled services;
- reviewed medical and billing records and, if necessary, followed up with physicians or their billing agents to request additional information to confirm the correct place of service, identify coding discrepancies, and identify the underlying causes that contributed to incorrect coding;
- followed up with outpatient hospitals and ASCs, when necessary, to verify that the sampled services were performed at the facilities;
- calculated amounts of any Medicare overpayments for sampled services;
- reviewed Common Working File history to ensure that claims with payment errors had not subsequently been adjusted;
- used a statistical projection to estimate the total value of erroneous claims, as described in Appendix C; and
- discussed the results of our review with NHIC officials.

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

FINDING AND RECOMMENDATIONS

Physicians did not always properly code the place of service on claims submitted to and paid by NHIC. Specifically, physicians incorrectly coded the place of service on 81 of the 100 sampled claims by using the office place of service code even though they performed the services in an outpatient hospital or an ASC. Physicians correctly coded 19 of the 100 sampled claims.

As a result of the incorrect coding, NHIC overpaid the physicians \$5,423 for the 81 sampled claims. Based on a statistical projection, we estimate that NHIC overpaid physicians \$4,254,613 for incorrectly coded services provided during the 2-year period that ended December 31, 2003. We attribute the overpayments to internal control weaknesses at the physician billing level.

PAYMENTS BASED ON INCORRECT PLACE OF SERVICE

Medicare Requirements

For a physician to receive the higher nonfacility practice expense payment for a service, the service must meet the requirements of 42 CFR § 414.22(b)(5)(i)(B):

The higher non-facility practice expense RVUs [relative value units] apply to services performed in a physician's office, a patient's home, an ASC if the physician is performing a procedure not on the ASC approved procedures list, a nursing facility, or a facility or institution other than a hospital or skilled nursing facility, community mental health center, or ASC performing an ASC approved procedure.

CMS publishes a physician fee schedule in the Federal Register showing those services having a higher payment rate if performed in a physician's office.

Overpayment Recovery Requirements

Medicare regulations (42 CFR §§ 405.370 through 405.378) specify that the Medicare contractors' responsibilities for recovering overpayments include issuing written demand letters, assessing interest, and recouping overpaid amounts. CMS's "Medicare Financial Management Manual" also provides guidance on recovering overpayments.

Services Billed With Incorrect Place of Service Codes

Physicians incorrectly coded the place of service for 81 of the 100 sampled services. Each of the 81 services was coded as though it had been performed in the physician's office and thus received a higher payment rate. However, 51 of the services were actually performed in outpatient hospital settings, and 30 were ASC-approved procedures performed in an ASC.

An Example of the Effects of Incorrect Coding

A physician was paid \$406 for a colonoscopy coded as being performed in his office. Our analysis showed that the physician actually performed the service in the ASC and should have received a payment of \$200. As a result, the physician was overpaid \$206.

By repricing the claims using the correct place of service code, we determined that NHIC overpaid physicians \$5,423 for the 81 services that physicians had billed incorrectly.

Estimate of Overpayments

We estimate that NHIC overpaid physicians \$4,254,613 for services provided from January 1, 2002, through December 31, 2003, that were billed using incorrect place of service codes. (See Appendix C.)

Internal Control Weaknesses at the Physicians' Offices

Many physicians had not implemented internal controls to prevent billings with incorrect place of service codes. Physicians and their billing personnel or billing agents told us that their offices coded place of service incorrectly for one or more of the following reasons:

- Physicians' billing personnel or billing agents were confused about the precise definition of a "physician's office" or were simply following established practice in applying the office place of service code.
- Physicians' billing agents were unaware that incorrect place of service codes could change the Medicare payment for a specific service.
- Personnel made isolated data entry errors.
- Undetected flaws in the design or implementation of some billing systems caused all claims to be submitted with "physician's office" as the place of service.

Nevertheless, we found that physicians and their staff were often at fault for repeatedly misapplying the office place of service code. The physicians and their staff used the office place of service code even though they knew, or should have known, that the service was not performed in the physician's office. Medicare claim form instructions specifically state that each provider or practitioner submitting claims to Medicare is responsible for becoming familiar with Medicare coverage and billing requirements.

RECOMMENDATIONS

We recommend that NHIC:

- recover the \$5,423 in overpayments for the sampled services,
- review our information on the additional 122,054 services estimated at \$4,249,190 that were potentially billed with an incorrect place of service code and work with the physicians who provided the services to recover any overpayments,
- strengthen its education process and reemphasize to physicians and their billing agents the importance of correctly reporting the place of service and the need for internal control systems to prevent Medicare billings with incorrect place of service codes, and
- work with the program safeguard contractor to develop a data match that will identify physician services having a high risk for place of service miscoding and to recover resulting program overpayments.

AUDITEE'S COMMENTS

In its comments on our draft report, NHIC generally agreed to implement our recommendations subject to (1) the 4-year reopening period specified in 42 CFR § 405.841 and (2) its analysis of data to achieve the maximum cost/recovery benefit. We have included NHIC's comments in their entirety as Appendix D.

APPENDIXES

**OFFICE OF INSPECTOR GENERAL
PLACE OF SERVICE CODING REPORTS**

Report Title and Number	Issue Date
“Review of Payments Made by National Heritage Insurance Company for Ambulatory Surgical Procedures for Calendar Year 2001” (A-01-02-00524)	July 23, 2003
“Review of Place of Service Coding For Physician Services - Wisconsin Physician Services, Madison, Wisconsin” (A-05-04-00025)	October 5, 2004
“Review of Place of Service Coding for Physician Services - Trailblazer Health Enterprises, LLC for the Period January 1, 2001 through December 31, 2002” (A-06-04-00046)	January 21, 2005
“Review of Place of Service Coding for Physician Services” (A-02-04-01010)	January 26, 2005

SAMPLING METHODOLOGY

OBJECTIVE

The objective of our audit was to determine whether physicians properly coded the place of service on claims submitted to and paid by National Heritage Insurance Company (NHIC).

POPULATION

The population included 122,154 services that were provided from January 1, 2002, to December 31, 2003, and were billed to Medicare Part B by physicians who may have used incorrect nonfacility place of service codes. NHIC processed and paid these services. These services, although coded as having been performed in nonfacility settings, were matched with data that indicated that the services might have been performed in an outpatient hospital or an ambulatory surgical center.

SAMPLE DESIGN

We designed a stratified random sample consisting of two strata. The first stratum consisted of 70 services billed as performed in a physician’s office that may have been performed in an outpatient hospital setting. The second stratum consisted of 30 services billed as performed in a physician’s office that may have been performed in an ambulatory surgical center.

Stratum	Description	Number of Population Claims	Payment Amounts
1	Physician–outpatient hospital setting	109,556	\$8,587,643
2	Physician–ambulatory surgical center	12,598	3,660,688
Total		122,154	\$12,248,331

SAMPLE SIZE

The sample consisted of 100 claims totaling \$14,163.95. We selected 70 claims from stratum 1 and 30 claims from stratum 2.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

The results of our review of the sampled claims were as follows:

Sample Results

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
Outpatient Hospital	70	\$5,203.37	51	\$1,726.69
Ambulatory Surgery Center	30	8,960.58	30	3,696.29
Total	<u>100</u>	<u>\$14,163.95</u>	<u>81</u>	<u>\$5,422.98</u>

VARIABLE PROJECTIONS

Projected Value of Erroneous Claims Precision at the 90-Percent Confidence Level

Point Estimate	\$4,254,613
Lower Limit	\$3,254,327
Upper Limit	\$5,254,899



November 2, 2006

Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region 1
John F Kennedy Federal Building
Boston, MA 02203

Attention: Michael J. Armstrong
Regional Inspector General for Audit Services

Subject: Office of Inspector General's Draft Report, "Review of Place of Service Coding for Physician Services Processed by National Heritage Insurance Company During Calendar Year 2002 and 2003" (A-01-06-00502).

Dear Mr. Armstrong:

NHIC is in receipt of the Office of Inspector General's (OIG) draft report dated October 4, 2006, as specified above, and appreciates the opportunity to provide comments. You may wish to note that, effective June 27, 2006, National Heritage Insurance Company changed our corporate name to "NHIC, Corp."

Please find on the following pages our response to the recommendations in the audit report cited above. If you have any questions about NHIC corrective actions, please contact Jennifer Otten, Manager of Audit & Controls, in Chico, California at 530-896-7143 (or at jennifer.otten@eds.com).

Sincerely,

Paul Ackerman
Director
NHIC, Corp.

CC: Eileen Turner, CMS
Anne Bockhoff-Dalton, NHIC, Corp.
Jane Hite, NHIC, Corp.
Robert Harrington Jr., NHIC, Corp.
Jennifer Otten, NHIC, Corp.

NHIC, Corp.

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Summary of OIG's recommendations and NHIC's response to each:**1. Recommendation**

Recover the \$5,423 in overpayments for the sampled services

NHIC Response

NHIC will initiate an overpayment recovery project to recover any overpayments which fall into the 4-year reopening period concluding on the date the OIG report is final (cf. 42 CFR 405.841). We anticipate completing this work by the end of 1st Quarter FY 2007.

2. Recommendation

Review the information on the additional 122,054 services which are estimated via projection to contain \$4,249,190 in overpayments due to incorrectly billed place of service codes, and work with the physicians involved to recover the Medicare funds

NHIC Response

NHIC will evaluate the complete file of potential overpayments upon receipt. It is our intent to analyze the data to achieve the maximum cost/recovery benefit. We anticipate completing this work by the end of 2nd Quarter FY 2007.

3. Recommendation

Strengthen the educational process and stress the importance of correctly reporting the place of service, and emphasize the need for effective controls over Medicare billings.

NHIC Response

Education specific to coding "place of service" (POS) 11 instead of 22 or 24 was initiated following review of a similar OIG Region 5 report (A-05-04-0025, October 2004). An article on our website was posted 11/18/2004, and was included in our December 2004 newsletter. The web article was recently updated and posted 09/28/2006.

Prior to this, NHIC published numerous articles pertaining to ASC billing and POS coding in general. We made available to any interested provider the full definitions both POS 11 (office), 22 (outpatient hospital) and 24 (ambulatory surgical center), and included this information in our seminars. The annual Fee Schedule disclosure also contains information on the facility and non-facility-based fee concept.

We anticipate completing this work by the end of 2nd Quarter FY 2007.

4. Recommendation

Work with the Program Safeguard Contractor (PSC) to develop a data match that will identify services having a high risk of miscoding-based overpayments of this type, and recover any resulting program overpayments.

NHIC Response

We will work with PSCs with contracts in our states and coordinate activities to identify additional overpayments. We anticipate completing this work by the end of 2nd Quarter FY 2007.