



NOV - 8 2007

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Report Number: A-01-07-00512

Ms. Anne Bockhoff Dalton  
Vice President  
NHIC, Corp.  
75 Sgt. William B. Terry Drive  
Hingham, MA 02043

Dear Ms. Bockhoff Dalton:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Medicare Part B Payments Made by National Heritage Insurance Company for Outpatient Laboratory Services Provided During Inpatient Stays in Calendar Year 2005." We will forward a copy of this report to the HHS action official noted on the following 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 this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Leah Scott, Audit Manager, at (617) 565-2679 or through e-mail at [leah.scott@oig.hhs.gov](mailto:leah.scott@oig.hhs.gov). Please refer to report number A-01-07-00512 in all correspondence.

Sincerely,

Michael J. Armstrong  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Thomas W. Lenz, Consortium Administrator  
Consortium for Financial Management and Fee for Service Operations  
Centers for Medicare & Medicaid Services  
601 E. 12<sup>th</sup> Street, Room 235  
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE PART B PAYMENTS  
MADE BY NATIONAL HERITAGE  
INSURANCE COMPANY FOR  
OUTPATIENT LABORATORY  
SERVICES PROVIDED DURING  
INPATIENT STAYS IN  
CALENDAR YEAR 2005**



Daniel R. Levinson  
Inspector General

November 2007  
A-01-07-00512

# ***Office of Inspector General***

<http://oig.hhs.gov>

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## **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**

Under Medicare's inpatient prospective payment system (PPS), fiscal intermediaries reimburse acute care hospitals a predetermined amount for essentially the entire package of services furnished to Medicare beneficiaries during inpatient stays. This payment is 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 that Medicare beneficiaries receive during an inpatient stay. These nonphysician outpatient services include laboratory services (excluding anatomic pathology services and certain clinical pathology services) furnished to inpatients by a physician's office, another hospital, or an independent laboratory.

Accordingly, laboratory suppliers that provide nonphysician outpatient services to Medicare beneficiaries during inpatient stays are required to bill the PPS hospital, not the Medicare carrier, for those services. Medicare carriers are responsible for ensuring that they do not pay inappropriately for laboratory services provided to hospital inpatients.

### **OBJECTIVE**

The objective of our audit was to determine whether the National Heritage Insurance Company (NHIC) made inappropriate Part B payments for outpatient laboratory services provided to Medicare beneficiaries during inpatient stays at PPS hospitals during calendar year (CY) 2005.

### **SUMMARY OF FINDING**

NHIC made inappropriate Part B payments for outpatient laboratory services provided to Medicare beneficiaries during inpatient stays at PPS hospitals during CY 2005. Based on our statistical sample, we estimate that NHIC paid laboratory suppliers \$292,524 for the technical component of laboratory services provided to hospital inpatients during CY 2005. As a result, the Medicare program paid twice for these services: once to the hospital as part of the DRG payment and again to the laboratory supplier under Part B. We attribute the overpayments to a lack of internal controls to prevent improper billing at the laboratory supplier.

### **RECOMMENDATIONS**

We recommend that NHIC:

- recover the \$13,101 in overpayments for the sampled services,
- review our information on the additional 13,650 services estimated at \$279,423 and work with the laboratory suppliers to recover any overpayments,

- reemphasize to laboratory suppliers the need for internal control systems to prevent improper billing for laboratory services provided to hospital inpatients, and
- adjust its existing prepayment edits to identify and deny payments for all laboratory services billed with the inpatient hospital place of service code.

#### **NATIONAL HERITAGE INSURANCE COMPANY'S COMMENTS**

In its written comments on our draft report, NHIC agreed with our finding and recommendations.

NHIC'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 essentially the entire package of services furnished to Medicare beneficiaries during inpatient stays. This payment is 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 that the beneficiary receives during an inpatient stay. These nonphysician outpatient services include the technical component of laboratory services. Thus, laboratory suppliers that provide outpatient services to Medicare beneficiaries during inpatient stays are required to bill the PPS hospital, not the Medicare carrier, for the technical component of those services.<sup>1</sup>

#### **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 ambulatory surgical centers. Medicare carriers are responsible for ensuring that they do not pay inappropriately for nonphysician services, such as the technical component of laboratory services provided to hospital inpatients.

#### **National Heritage Insurance Company**

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. To prevent inappropriate payments, NHIC established edits in its claims processing system to identify and deny payments for laboratory services billed with certain place of service codes, including the inpatient hospital place of service.

### **OBJECTIVE, SCOPE, AND METHODOLOGY**

#### **Objective**

The objective of our audit was to determine whether NHIC made inappropriate Part B payments for outpatient laboratory services provided to Medicare beneficiaries during inpatient stays at PPS hospitals during calendar year (CY) 2005.

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<sup>1</sup> Independent laboratories are allowed to bill Medicare Part B for the technical component of anatomic pathology services and certain clinical pathology services that they furnish to hospital inpatients.

## Scope

We identified and reviewed potential overpayments that NHIC made for claims with dates of service in CY 2005. Because our objective did not require an understanding or assessment of the complete internal control structure of NHIC, we limited consideration of the internal control structure to NHIC's Part B claims processing systems, specifically as they relate to processing payment for outpatient laboratory services provided to Medicare beneficiaries during inpatient stays at PPS hospitals. We also did not assess the completeness of the file extracted from CMS's National Claims History File.

We performed our audit work from March to July 2007.

## Methodology

To accomplish our objectives, we:

- reviewed applicable Medicare requirements;
- performed a computer match (using CMS's National Claims History File) to identify Medicare Part B payments during CY 2005 for outpatient laboratory services provided to Medicare beneficiaries during inpatient stays at PPS hospitals, excluding services provided on the dates of admission and discharge;
- eliminated certain pathology procedure codes whose technical component can be billed to Medicare Part B by independent laboratories;
- limited our population to laboratory procedure codes that occurred 100 or more times during the year;
- stratified the population of 6,275 beneficiary days, on which 14,094 Part B laboratory services were provided to hospital inpatients, into 4 strata based on the dollar amount paid per beneficiary day;<sup>2</sup>
- selected for review 108 beneficiary days comprising 30 randomly selected days each from strata 1 and 2, 40 randomly selected days from stratum 3, and all 8 days from stratum 4 (see Appendix A);
- contacted 79 hospitals to verify admission and discharge dates for the sampled claims to ensure that no leaves-of-absence had disrupted the inpatient stays;

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

- contacted representatives from 27 of the 34 Part B laboratory suppliers to determine why the suppliers had billed the Medicare carrier instead of the hospitals for the services provided;<sup>3</sup>
- contacted NHIC to determine how the edits in its claims processing systems detected and prevented Part B payments for the technical component of laboratory services; and
- used a variable appraisal program for a stratified random sample to estimate the total value of overpayments (see Appendix B).

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

## **FINDING AND RECOMMENDATIONS**

NHIC made inappropriate Part B payments for outpatient laboratory services provided to Medicare beneficiaries during inpatient stays at PPS hospitals during CY 2005. Based on our statistical sample, we estimate that NHIC paid laboratory suppliers \$292,524 for the technical component of laboratory services provided to hospital inpatients during CY 2005. As a result, the Medicare program paid twice for these services: once to the hospital as part of the DRG payment and again to the laboratory supplier under Part B. We attribute the overpayments to a lack of internal controls to prevent improper billing at the laboratory supplier.

### **PROGRAM REQUIREMENTS**

According to the “Medicare Claims Processing Manual,” Chapter 3, section 10.4, laboratory suppliers that provide services to Medicare beneficiaries during inpatient stays are required to bill the PPS hospital, not the Medicare carrier, for the technical component of these services.

Medicare requires laboratory suppliers to identify the place of service code on the health insurance claim forms that they submit to the Medicare carriers. According to the “Medicare Claims Processing Manual,” Chapter 26, sections 10.4 and 10.6, when a service is provided to a hospital inpatient, the hospital inpatient place of service code must be used.

### **RESULTS OF POTENTIAL OVERPAYMENTS**

During CY 2005, NHIC made inappropriate Part B payments for the technical component of laboratory services provided to hospital inpatients. Our computer match for CY 2005 identified 14,094 laboratory services provided on 6,275 beneficiary days that may have been inappropriately paid.

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<sup>3</sup>Because we were unable to locate the remaining seven Part B laboratory suppliers, we validated their payments with NHIC.

To verify that our computer match was valid, we selected a sample of 108 beneficiary days, for which Medicare payments for all services provided totaled \$20,179. We found the following:

- For 22 of the 108 sampled days, laboratory supplier officials:
  - billed incorrectly because of clerical error (3 sampled items),
  - billed incorrectly with no specific reason given (3 sampled items), or
  - did not know that the beneficiary was an inpatient at the time the laboratory services were provided (16 sampled items).
- For 7 of the 108 sampled days, the supplier billed the wrong date of service. Our computer match identified these payments as inappropriate because the laboratory supplier submitted incorrect information.<sup>4</sup>
- For 55 of the 108 sampled days, laboratory suppliers did not respond to our request for additional information.
- For 4 of the 108 sampled days, the laboratory supplier refunded the Medicare Part B payments before we began our audit; therefore, we did not consider these beneficiary days to be errors.
- The remaining 20 of the 108 sampled days were allowable because they were billed in conjunction with pathology procedures that we had excluded from the population.

## **ESTIMATED OVERPAYMENTS TO LABORATORY SUPPLIERS**

Our review of the sampled items indicated that carriers had incorrectly paid for laboratory services totaling \$13,101. Extrapolating these results to the population, we estimated that NHIC had overpaid laboratory suppliers by \$292,524. As a result, the Medicare program paid twice for these services: once to the hospital as part of the DRG payment and again to the laboratory supplier under Part B.

## **NEED FOR STRONGER INTERNAL CONTROLS**

Laboratory suppliers had not established internal controls to prevent inappropriate billing for the technical component of laboratory services provided to hospital inpatients. Because most of these laboratory suppliers did not use the inpatient hospital place of service code when they billed the carrier, the edits in place in NHIC's claims processing systems generally could not detect and prevent inappropriate payments.

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<sup>4</sup> We acknowledge that some of these sampled items might be reimbursable under Part B if the laboratory suppliers resubmit the claims after the erroneous date of service is corrected.

In addition, NHIC's edits were not designed to identify and deny payment for all laboratory services billed with the inpatient hospital place of service code. As a result, our computer match showed that NHIC made \$21,630 in payments to California laboratory suppliers for services that were billed with the inpatient hospital place of service code during CY 2005.

## **RECOMMENDATIONS**

We recommend that NHIC:

- recover the \$13,101 in overpayments for the sampled services,
- review our information on the additional 13,650 services estimated at \$279,423 and work with the laboratory suppliers to recover any overpayments,
- reemphasize to laboratory suppliers the need for internal control systems to prevent improper billing for laboratory services provided to hospital inpatients, and
- adjust its existing prepayment edits to identify and deny payments for all laboratory services billed with the inpatient hospital place of service code.

## **NATIONAL HERITAGE INSURANCE COMPANYS'S COMMENTS**

In its comments on our draft report, NHIC agreed with our finding and recommendations.<sup>5</sup>

We have included NHIC's comments in their entirety as Appendix C.

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<sup>5</sup> In response to NHIC's additional comment that CMS consider implementing a national edit in its Common Working File, we note that we will forward this report to a CMS action official.

# **APPENDIXES**

## SAMPLING METHODOLOGY

### OBJECTIVE

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

### POPULATION

The population consisted of beneficiary days containing laboratory procedure codes that occurred 100 or more times during the year.

### SAMPLE DESIGN

The audit used a stratified random sample consisting of four strata based on the dollar amount paid per beneficiary day.

Stratum	Number of Beneficiary Days	Number of Services	Medicare Payments
<b>1 – Overpayments \$20.00 or less</b>	3,991	4,622	\$ 30,566
<b>2 – Overpayments \$20.01 to \$90.00</b>	1,039	2,985	49,594
<b>3 – Overpayments \$90.01 to \$600.00</b>	1,237	6,384	338,043
<b>4 – Overpayments \$600.01 or greater</b>	8	103	6,840
<b>Total</b>	<b>6,275</b>	<b>14,094</b>	<b>\$425,043</b>

### SAMPLE SIZE

The sample consisted of 108 beneficiary days comprising 30 randomly selected days each from strata 1 and 2, 40 randomly selected days from stratum 3, and all 8 days from stratum 4.

## SAMPLE RESULTS AND PROJECTONS

## SAMPLE RESULTS

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
1 – Overpayments \$20.00 or less	30	\$ 176	28	\$ 162
2 – Overpayments \$20.01 to \$90.00	30	1,658	28	1,479
3 – Overpayments \$90.01 to \$600.00	40	11,505	23	6,959
4 – Overpayments \$600.01 or greater	8	6,840	5	4,501
<b>Total</b>	<b>108</b>	<b>\$20,179</b>	<b>84</b>	<b>\$13,101</b>

## VARIABLE PROJECTIONS

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

Point Estimate	\$292,524
Lower Limit	\$234,713
Upper Limit	\$350,335



Phone: (213) 593-6192

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October 30, 2007

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, "Medicare Part B Payments Made by National Heritage Insurance Company for Outpatient Laboratory services Provided During Inpatient Stays in Calendar Year 2005" (A-01-07-00512).

Dear Mr. Armstrong:

NHIC is in receipt of the Office of Inspector General's (OIG) draft report dated October 1, 2007, as specified above, and appreciates the opportunity to provide comments.

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](mailto:jennifer.otten@eds.com)).

Sincerely,

Paul Ackerman  
Director  
NHIC, Corp.

CC: Dolores Buendia, 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 \$13,101 in overpayments for the sample services.

**NHIC Response**

NHIC has begun our analysis of the data provided to us by the OIG, and will initiate recovery actions for the cited services by the March 31, 2008.

**2. Recommendation**

Review the information on the additional 13,650 services estimated at \$279,423 and work with the laboratory suppliers to recover any overpayments.

**NHIC Response**

Once NHIC receives the data relating to the additional services, we will begin the process of confirming the validity of the overpayments, and will initiate recovery of the program funds by June 30, 2008.

**3. Recommendation**

Reemphasize to laboratory suppliers the need for internal controls systems to prevent improper billing of laboratory services rendered to hospital inpatients

**NHIC Response**

NHIC will include educational language in our overpayment demand letters which addresses this issue with both the sampled providers (Recommendation 1) and the providers identified in the larger dataset (Recommendation 2). Additionally, on September 20, 2007, NHIC published an article on our website which addresses this and other related laboratory concerns.

(Link: [http://www.medicarenhic.com/cal\\_prov/articles/labtestbill\\_0907.pdf](http://www.medicarenhic.com/cal_prov/articles/labtestbill_0907.pdf))

**4. Recommendation**

Adjust our existing prepayment edits to identify and deny payments for all laboratory services billed with the inpatient hospital place of service codes.

**NHIC Response**

NHIC has already adjusted our internal editing to avoid payment of any clinical laboratory tests when billed with inpatient place of service codes.

**Additional Comments**

NHIC believes that both place of service editing at NHIC, and strengthened laboratory internal controls, will bring about an overall reduction in the type of payment errors noted in the report.

We believe that CMS may wish to consider a national Common Working File (CWF) edit which will allow claims to be queried against Intermediary hospital inpatient claim records, and thus identify potentially misbilled services prior to payment. Concurrently, a matching "unsolicited" edit can be created to identify misbilled services "after the fact," and facilitate efficient and prompt recovery of funds.

OIG Audit A-01-07-00512 Response (page 3 of 3)

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Effective edits of this type for Part B claims already exist--most recently for ambulance and radiology services--and are planned in 2008 for the technical component of physician pathology services. NHIC believes that a national CWF edit will achieve the greatest reduction in overpayments that occur when a laboratory bills the Part B Contractor for services rendered to hospital inpatients.