



December 17, 2010

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Joe Green/ for
George M. Reeb
Acting Deputy Inspector General for Audit Services

SUBJECT: Payments for Ambulatory Surgical Center Services Provided to Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A in Calendar Years 2006 through 2008 (A-01-09-00521)

The attached final report provides the results of our review of payments for Ambulatory Surgical Center services provided to beneficiaries in skilled nursing facility stays covered under Medicare Part A in calendar years 2006 through 2008.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that the Office of Inspector General (OIG) post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov. We look forward to receiving your final management decision within 6 months. Please refer to report number A-01-09-00521 in all correspondence.

Attachment

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**PAYMENTS FOR AMBULATORY
SURGICAL CENTER SERVICES
PROVIDED TO BENEFICIARIES IN
SKILLED NURSING FACILITY
STAYS COVERED UNDER
MEDICARE PART A IN CALENDAR
YEARS 2006 THROUGH 2008**



Daniel R. Levinson
Inspector General

December 2010
A-01-09-00521

Office of Inspector General

<http://oig.hhs.gov>

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Section 1888(e) of the Social Security Act (the Act) established a prospective payment system for skilled nursing facilities (SNF). Under the prospective payment system, Medicare pays SNFs for all covered SNF services. Pursuant to the Act's consolidated billing requirements, SNFs are responsible for billing Medicare for virtually all services furnished to SNF residents during a Part A covered stay, regardless of whether SNFs furnish the services directly or under arrangements with outside suppliers. For services furnished under arrangements with outside suppliers, the suppliers are responsible for billing the SNFs (rather than Medicare Part B). Therefore, Medicare Part B payments that suppliers receive for these services are overpayments.

Ambulatory surgical center (ASC) facility services, such as nursing, recovery care, anesthetics, drugs, and other supplies, provided to SNF residents are subject to consolidated billing and must be billed to the SNF rather than Medicare Part B. Physicians' professional services are statutorily excluded from consolidated billing and may be billed to Medicare Part B.

Our nationwide audit covered 20,906 Medicare Part B ASC facility services valued at \$7,113,542 with dates of service in calendar years (CY) 2006 through 2008 that matched 14,192 Part A SNF stays and that thus represented potential overpayments. We sampled 100 services provided by 88 ASCs.

OBJECTIVE

Our objective was to determine whether ASCs complied with consolidated billing requirements in CYs 2006 through 2008.

SUMMARY OF FINDINGS

ASCs did not comply with consolidated billing requirements in CYs 2006 through 2008. All 100 services that we reviewed, totaling \$102,879, were incorrectly billed to Medicare Part B even though they were included in the SNFs' Part A payments. As a result, Medicare paid twice for these services: once to the SNF under the Part A prospective payment system and again to the ASC under Part B.

Based on our sample results, we estimated that Medicare contractors made at least \$6.6 million in overpayments to ASCs for services provided to beneficiaries in Part A SNF stays in CYs 2006 through 2008. These overpayments occurred because ASCs did not have the necessary controls to prevent incorrect billing to Medicare Part B. In addition, the payment controls in the Centers for Medicare & Medicaid Services' (CMS) Common Working File were not designed to prevent and detect Part B overpayments to ASCs for services subject to consolidated billing.

RECOMMENDATIONS

We recommend that CMS:

- instruct its Medicare contractors to:
 - recover the \$102,879 in overpayments for the 100 incorrectly billed services that we identified,
 - review the 20,806 services that we did not review and recover overpayments estimated to total at least \$6.5 million, and
 - provide guidance to ASCs on consolidated billing requirements and the need for timely and accurate communication between ASCs and SNFs regarding beneficiaries' Medicare Part A status and
- establish an edit in the Common Working File to prevent Part B payments for ASC services that are subject to consolidated billing.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. CMS requested that we provide the data necessary to recover overpayments for the sampled and nonsampled services. With respect to the nonsampled services, CMS stated that it would share this report and the additional claims with the recovery audit contractors. CMS's comments are included in their entirety as Appendix E.

We will provide CMS with the requested data.

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INTRODUCTION

BACKGROUND

Skilled Nursing Facility Prospective Payment System and Consolidated Billing Requirements

Section 1888(e) of the Social Security Act (the Act) established a prospective payment system for skilled nursing facilities (SNF) for cost-reporting periods beginning on or after July 1, 1998. Under the prospective payment system, Medicare pays SNFs through per diem, prospective, case-mix-adjusted payment rates for all SNF covered services. Under the consolidated billing provisions of sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for all services furnished to a SNF resident during a Part A covered stay, except for specifically excluded services, regardless of whether SNFs furnish the services directly or under arrangements with outside suppliers. For services furnished under arrangements with outside suppliers, the suppliers are responsible for billing the SNFs (rather than Medicare Part B).

Ambulatory Surgical Centers

An ambulatory surgical center (ASC) is a facility, other than a physician's office, where surgical and diagnostic services are provided on an outpatient basis. The procedures most commonly performed in ASCs are colonoscopies, cataract removal, and other eye procedures.

Medicare Part B makes prospective payments to ASCs for facility services, such as nursing, recovery care, anesthetics, drugs, and other supplies. However, for services furnished to SNF residents, ASCs must bill according to the consolidated billing provisions and be paid by the SNF rather than Medicare Part B. Accordingly, when an ASC erroneously bills Part B for services included in the SNF's Part A payment, Medicare pays for these services twice: once to the SNF and again to the ASC.

Physicians' professional services are statutorily excluded from consolidated billing.

Medicare Contractors

The Centers for Medicare & Medicaid Services (CMS) contracts with Medicare contractors to process and pay Medicare Part B claims.¹ Medicare contractors use the Medicare Multi-Carrier System and CMS's Common Working File to process Part B claims. These systems can prevent or detect certain improper payments.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MACs) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

Prior Office of Inspector General Reports

Prior Office of Inspector General audits, which are listed in Appendix A, identified a total of \$444 million in Medicare Part B overpayments to suppliers on behalf of beneficiaries during Part A SNF stays. These audits covered various periods from calendar year (CY) 1998 through CY 2006.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether ASCs complied with consolidated billing requirements in CYs 2006 through 2008.

Scope

Our nationwide audit covered 20,906 Medicare Part B ASC facility services valued at \$7,113,542 with dates of service in CYs 2006 through 2008 that coincided with dates of service for 14,192 Part A SNF stays and that thus represented potential overpayments.

We limited our internal control review at CMS and selected Medicare contractors to the payment controls in place to prevent and detect Part B overpayments to ASCs for services included in Medicare Part A payments to SNFs. We limited our internal control review at ASCs to those controls related to developing and submitting Medicare claims for services provided to beneficiaries during Part A SNF stays.

Our fieldwork consisted of contacting 88 ASCs and 93 SNFs nationwide from February through May 2010. We also contacted three Medicare contractors.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used data from CMS's National Claims History file to perform a nationwide computer match of ASC services and SNF claims to identify ASC services with Medicare overpayments for CYs 2006 through 2008 (Appendix B);
- selected a stratified random sample of 100 services from the 20,906 ASC services identified by our computer match (Appendix C) and, for the sampled services:
 - reviewed available data from CMS's Common Working File and the corresponding SNF claims to validate the results of our computer match,

- contacted representatives from the 88 ASCs that submitted claims for the sampled services to confirm the overpayments and to determine the underlying causes of noncompliance with Medicare requirements, and
- contacted the 93 SNFs associated with the ASC services to verify admission and discharge dates;
- contacted CMS and 3 Medicare contractors to obtain an understanding of the consolidated billing edits in the Common Working File;
- estimated the overpayments that Medicare contractors made to ASCs nationwide for services provided in CYs 2006 through 2008 (Appendix D); and
- discussed the results of our review with CMS.

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.

FINDINGS AND RECOMMENDATIONS

ASCs did not comply with consolidated billing requirements in CYs 2006 through 2008. All 100 services that we reviewed, totaling \$102,879, were incorrectly billed to Medicare Part B even though they were included in the SNFs' Part A payments. As a result, Medicare paid twice for these services: once to the SNF under the Part A prospective payment system and again to the ASC under Part B.

Based on our sample results, we estimated that Medicare contractors made at least \$6.6 million in overpayments to ASCs for services provided to beneficiaries in Part A SNF stays in CYs 2006 through 2008. These overpayments occurred because ASCs did not have the necessary controls to prevent incorrect billing to Medicare Part B. In addition, the payment controls in CMS's Common Working File were not designed to prevent and detect Part B overpayments to ASCs for services subject to consolidated billing.

PROGRAM REQUIREMENTS

Pursuant to sections 1862(a)(18) and 1842(b)(6)(E) of the Act, SNFs are responsible for billing Medicare for most services, including ASC services, provided to a SNF resident during a Part A stay. The interim final rule implementing the SNF consolidated billing requirement (63 Fed. Reg. 26252, 26300 (May 12, 1998)) states that "[w]hen the SNF furnishes services under an arrangement with an outside supplier, the outside supplier must look to the SNF instead of to Medicare Part B for payment" Accordingly, when an outside supplier erroneously bills Part B for services included in the SNF's Part A payment, Medicare pays for the services twice: once to the SNF and again to the outside supplier (63 Fed. Reg. 26252, 26295 (May 12, 1998)).

Physicians' professional services are statutorily excluded from consolidated billing pursuant to sections 1842(b)(6)(E) and 1888(e)(2)(A)(ii) of the Act.

INCORRECT PART B BILLING

ASCs incorrectly billed Medicare Part B for all 100 services that we reviewed. These services were provided to SNF residents during Part A stays and were thus subject to consolidated billing. The incorrect billing resulted in overpayments totaling \$102,879.

Example: Overpayment Billed by an ASC

A beneficiary was admitted to a SNF on August 12, 2008, as a resident covered under Medicare Part A. The beneficiary arrived at the SNF with a physician's order for a cystoscopy, which was performed on August 22, 2008, at an ASC. The physician who performed the cystoscopy correctly billed Medicare Part B for professional services and received a payment of \$105. The ASC incorrectly billed Medicare Part B, rather than the SNF, for its facility services and was paid \$260.

The beneficiary was discharged from the SNF on September 6, 2008, and the SNF was paid \$7,947 for the beneficiary's Part A stay. Because the services that the ASC furnished to the beneficiary were included in the SNF's Medicare Part A payment, Medicare incorrectly paid the ASC \$260 for its facility services.

Based on the results of our sample, we estimated that Medicare contractors nationwide made at least \$6.6 million in overpayments to ASCs for services subject to consolidated billing.

CAUSES OF OVERPAYMENTS

ASCs were either unaware of or did not fully understand consolidated billing requirements. In some instances, ASC officials stated that they were unaware that the exclusion of certain intensive hospital outpatient procedures from consolidated billing requirements, as provided in 42 CFR § 411.15(p)(3)(iii), does not apply if the services are performed in ASCs. Additionally, most ASCs did not ask beneficiaries during the check-in process whether they were currently Part A SNF residents.

Medicare contractors made overpayments to ASCs for services subject to consolidated billing because the edits in CMS's Common Working File were not designed to prevent and detect these overpayments.

RECOMMENDATIONS

We recommend that CMS:

- instruct its Medicare contractors to:
 - recover the \$102,879 in overpayments for the 100 incorrectly billed services that we identified,
 - review the 20,806 services that we did not review and recover overpayments estimated to total at least \$6.5 million, and
 - provide guidance to ASCs on consolidated billing requirements and the need for timely and accurate communication between ASCs and SNFs regarding beneficiaries' Medicare Part A status and
- establish an edit in the Common Working File to prevent Part B payments for ASC services that are subject to consolidated billing.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In comments on our draft report, CMS concurred with our recommendations and described the corrective actions that it was taking or planned to take. CMS requested that we provide the data necessary to recover overpayments for the sampled and nonsampled services. With respect to the nonsampled services, CMS stated that it would share this report and the additional claims with the recovery audit contractors. CMS's comments are included in their entirety as Appendix E.

We will provide CMS with the requested data.

APPENDIXES

APPENDIX A: PRIOR OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number¹	Period Covered by Review	Total Overpayments Identified	Issue Date
<i>Review of Compliance With the Consolidated Billing Provision Under the Prospective Payment System for Skilled Nursing Facilities (A-01-99-00531)</i>	Oct. 1, 1998, through April 30, 1999	\$0	Mar. 27, 2000
<i>Review of Potential Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System (A-01-00-00538)</i>	Calendar year (CY) 1999	\$47.6 million ²	June 5, 2001
<i>Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities (A-01-00-00509)</i>	CYs 1996 through 1998	\$35 million	July 23, 2001
<i>Medicare Part B Payments for Durable Medical Equipment Provided to Beneficiaries in Skilled Nursing Facilities for Time Periods Between the Full Month Periods Covered by Our Prior Report and the Date of Discharge From the Skilled Nursing Facility (A-01-01-00513)</i>	CYs 1996 through 1998	\$10.5 million	Oct. 17, 2001
<i>Review of Improper Payments Made by Medicare Part B for Services Covered Under the Part A Skilled Nursing Facility Prospective Payment System in Calendar Years 1999 and 2000 (A-01-02-00513)</i>	CYs 1999 through 2000	\$108.3 million	May 28, 2004
<i>Payments for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A (A-01-05-00511)</i>	CYs 1999 through 2003	\$112 million	June 26, 2007
<i>Payments for Outpatient Hospital, Laboratory, and Radiology Services Made on Behalf of Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A (A-01-06-00503)</i>	CYs 2001 through 2003	\$124.8 million	Jan. 30, 2008
<i>Review of Payments for Ambulance Transportation Provided to Beneficiaries in Skilled Nursing Stays Covered Under Medicare Part A in Calendar Year 2006 (A-01-08-00505)</i>	CY 2006	\$12.7 million	Aug. 25, 2009

¹ With the exception of report number A-01-01-00513, which was issued as an addendum to report number A-01-00-00509, these reports are available at <http://oig.hhs.gov>.

² As noted in report number A-01-02-00513, we reduced the \$47.6 million to \$40.7 million to account for overpayments refunded by suppliers after this review, as well as refinements in our matching methodology.

APPENDIX B: COMPUTER MATCH METHODOLOGY TO IDENTIFY OVERPAYMENTS

COMPILING DATA TO IDENTIFY OVERPAYMENTS

Skilled Nursing Facility Data

For skilled nursing facility (SNF) claims, we:

- extracted claim information from the National Claims History file for CYs 2006 through 2008;
- limited the population to claims with revenue center code 0022, denoting a prospective payment; and
- sorted claims by beneficiary and admission date and grouped the sorted claims together to identify SNF stays.

Ambulatory Surgical Center Services

For ambulatory surgical center (ASC) services, we:

- extracted paid claim information from the National Claims History file for CYs 2006 through 2008,
- eliminated services provided on the date of admission or discharge from the SNF,
- limited the population of services to those denoted by type of service code F (ASC Facility Usage for Surgical Services), and
- matched the paid claim information to the grouped SNF stays based on beneficiaries' health insurance claim numbers from the SNF claim data.

IDENTIFYING OVERPAYMENTS

To identify overpayments, we eliminated the following:

- services that had a \$0 Medicare payment, \$0 coinsurance payment, and \$0 deductible and
- services provided during the noncovered portion of the SNF stay.

APPENDIX C: SAMPLING DESIGN AND METHODOLOGY

POPULATION

The population consisted of Medicare Part B services furnished in ASCs nationwide on behalf of beneficiaries in Part A SNF stays during CYs 2006 through 2008.

SAMPLING FRAME

The sampling frame was a database of 20,906 ASC facility services totaling \$7,113,542 provided to beneficiaries in Part A SNF stays during CYs 2006 through 2008. We stratified the frame into three strata based on Medicare paid amounts.

Stratum	Medicare Paid Amount	Number of Services	Dollar Amount ¹
1	Payments of \$0 to \$300	10,692	\$2,014,740
2	Payments greater than \$300 to \$1,400	10,189	5,021,627
3	Payments greater than \$1,400	25	77,174
Total		20,906	\$7,113,542

SAMPLE UNIT

The sample unit was an ASC facility service furnished on behalf of a beneficiary in a Part A SNF stay.

SAMPLE DESIGN

We used a stratified random sample.

SAMPLE SIZE

The sample consisted of 100 services: 38 services from stratum 1, 37 services from stratum 2, and all 25 services in stratum 3.

SOURCE OF RANDOM NUMBERS

We used the Office of Inspector General, Office of Audit Services, random number generator to generate the random numbers.

¹ Does not add to total because of rounding.

METHOD OF SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the frame from 1 to 10,692 for stratum 1 and from 1 to 10,189 for stratum 2. After generating 38 random numbers for stratum 1 and 37 for stratum 2, we selected the corresponding frame items. For stratum 3, we selected all services.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the overpayments.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Sample Results

Stratum	Frame Size	Sample Size	Value of Sample	Number of Overpayments	Value of Overpayments
1	10,692	38	\$7,328	38	\$7,328
2	10,189	37	18,377	37	18,377
3	25	25	77,174	25	77,174
Total	20,906	100	\$102,879	100	\$102,879

Estimated Value of Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Lower limit	\$6,637,934
Upper limit	7,761,159
Point estimate	7,199,546



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator

Washington, DC 20201

DATE: NOV 18 2010**TO:** Daniel R. Levinson
Inspector General**FROM:** Donald M. Berwick, M.D.
Administrator

A handwritten signature in black ink, appearing to read "Donald M. Berwick", written over a horizontal line.

SUBJECT: Office of Inspector General's Draft Report: "Payments for Ambulatory Surgical Center Services Provided to Beneficiaries in Skilled Nursing Facility Stays Covered under Medicare Part A in Calendar Years 2006 through 2008"
(A-01-09-00521)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review the Office of Inspector General's (OIG) draft report entitled "Payments for Ambulatory Surgical Center Services Provided to Beneficiaries in Skilled Nursing Facility Stays Covered Under Medicare Part A in Calendar Years 2006 through 2008."

The objective of the review was to determine whether Ambulatory Surgical Centers (ASCs) complied with skilled nursing facility (SNF) consolidated billing requirements in calendar years (CYs) 2006 through 2008.

The OIG found that from 2006 to 2008, ASCs did not comply with consolidated billing requirements. All 100 services that were reviewed, totaling \$102,879, were incorrectly billed to Medicare Part B even though they were included in the SNF's Part A payments. As a result, Medicare paid twice for these services: once to the SNF under the SNF prospective payment system and again to the ASC under Part B. Based on the sample results, OIG estimated that Medicare contractors made at least \$6.6 million in overpayments to ASCs for services provided to beneficiaries in Part A SNF stays in CYs 2006 through 2008. According to the OIG, these overpayments occurred because ASCs did not have the necessary controls to prevent incorrect billing to Medicare Part B. In addition, the OIG determined that the payment controls in CMS's Common Working File (CWF) were not designed to prevent and detect Part B overpayments to ASCs for services subject to consolidated billing.

OIG Recommendation

OIG recommends that CMS instruct its Medicare contractors to recover the \$102,879 in overpayments for the 100 incorrectly billed services that were identified.

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CMS Response

The CMS concurs that the \$102,879 in overpayments should be recovered. The CMS plans to recover the overpayments identified consistent with the agency's policies and procedures.

We ask that the OIG furnish for each overpayment or potential overpayment the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.) to initiate and complete recovery action. In addition, Medicare contractor specific data should be written to separate cd-roms or separate hardcopy worksheets in order to better facilitate the transfer of information to the appropriate contractors.

OIG Recommendation

CMS should review the 20,806 services that OIG did not review and recover overpayments estimated to total at least \$6.5 million.

CMS Response

The CMS concurs. The CMS will take appropriate action to forward the listing of questionable claims to the Recovery Audit Contractors (RACs) and Medicare Administrative Contractors (MACs). The RACs review Medicare claims on a post payment basis and are tasked with identifying inappropriate payments. While CMS does not mandate areas for RAC review, we will share this information with them. We will instruct the MACs to consider this issue when prioritizing their medical review strategies or other interventions.

OIG Recommendation

CMS should provide guidance to ASCs on consolidated billing requirements and the need for timely and accurate communication between ASCs and SNFs regarding beneficiaries' Medicare Part A status.

CMS Response

The CMS concurs. On February 5, 2010, CMS issued change request (CR) 6702, "Implementation of a New Skilled Nursing Facility Consolidated Billing Edit Billed by Ambulatory Surgical Centers." Along with this CR, we developed a Medicare Learning Network Matters article, MM6702, to correspond to the CR. The article is posted on the CMS Web site and a link to it is also on the Medicare contractors' Web sites. The article serves as guidance to the ASCs regarding beneficiaries in a Part A SNF stay receiving services in an ASC.

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OIG Recommendation

OIG recommends that CMS instruct its Medicare contractors to establish an edit in the CWF to prevent Part B payments for ASC services that are subject to consolidated billing.

CMS Response

The CMS concurs. As noted above, CMS issued CR 6702, “Implementation of a New Skilled Nursing Facility Consolidated Billing Edit Billed by Ambulatory Surgical Centers.” This CR implements a new edit in the CWF to prevent separate payment for facility costs billed by ASCs for Medicare beneficiaries in Part A SNF stays. The edit was effective for claims with dates of service on or after January 1, 2008 that are processed on or after July 6, 2010.

The CMS commends the OIG for their analysis of ASC and SNF claims data and for providing us with the opportunity to comment on their findings. We look forward to the OIG follow-up studies to this report and look forward to working with you closely to ensure accurate ASC and SNF payments under Medicare.