PUBLICATION

OIG Finds Acute Care Hospitals Improperly Billed for Outpatient Services Provided to Inpatients of Other Hospitals

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Acute care hospitals that provide Medicare outpatient services to inpatients of other hospitals should be billing and collecting payment from the other inpatient hospitals and not from Medicare.

In a Report released on September 18, the Office of the Inspector General (OIG) found CMS had inappropriately paid more than $51.6 million between January 2013 and August 2016 for outpatient services acute care hospitals provided to Medicare beneficiaries who were inpatients at facilities other than acute care hospitals. The Report examined four types of non-acute care hospitals: (1) long term care hospitals; (2) inpatient rehabilitation facilities; (3) inpatient psychiatric facilities; and (4) critical access hospitals. In addition to payments from Medicare, the acute care hospitals collected $14.4 million in deductible and co-insurance amounts for these services from Medicare beneficiaries. While the Report noted the possibility that the acute care hospitals received payment from both Medicare and an under arrangement contract, the OIG did not verify whether the inpatient facilities paid the acute care facilities for the services rendered or if the inpatient facilities included the outpatient services on their Part A claims.

Acute care hospitals are paid for inpatient services through the Inpatient Prospective Payment System under Medicare Part A and paid for outpatient services under Medicare Part B. Other types of hospitals, including the four types examined in the Report, are paid under a different prospective payment system or based upon reasonable costs. The hospitals reviewed are responsible for providing all services to inpatients, either directly or via an arrangement with another provider. The Report found that acute care hospitals had been paid under Part B for outpatient services provided to inpatients of these other hospitals despite the Medicare payments these other hospitals received, which were intended to cover all services.

Instead of Part B payments, the non-acute care hospitals should have paid the acute care hospitals for the outpatient services via their contractual arrangements. The services provided by the acute care hospitals in the study included surgical procedures, computed tomography scans, x-rays and other radiological services, laboratory services, emergency department visits, drug injections, echocardiography, infusion services, and ambulance services.

The OIG determined that Medicare overpaid the acute care hospitals because certain common working file (CWF) edits and processes were not properly working. Specifically, in 94 percent of the cases, Medicare processed the acute care hospitals' claims for outpatient services before receiving the inpatient hospitals' claims for inpatient services. In that situation, a post-payment edit alerted the Medicare contractor to recover the outpatient services payment, but the contractor did not seek to recover the payment. In the remaining six percent of the cases, the Medicare contractor processed the inpatient claim before it received the acute care hospital outpatient claim, but the system failed to generate the prepayment edit to deny the outpatient claim. These failures in the system resulted in $51,640,727 in improper payments by Medicare to the acute care facilities and $14,365,590 in deductible and copayment amounts improperly paid by Medicare beneficiaries for the outpatient services.

CMS concurred with all the OIG's recommendations. These included: (1) recovering the Medicare overpayments to acute care hospitals; (2) instructing acute care hospitals to refund improperly collected patient

deductible and co-insurance amounts; (3) correcting the CWF edits and processes to avoid these errors in the future; and (4) directing Medicare contractors to educate acute care hospitals not to bill Medicare for outpatient services provided to beneficiaries who were inpatients of other facilities. The Report also found that while the audit covered only a 41-month period through August 2016, improper payments may have been made after this period. CMS is conducting an analysis to determine how to address any improper payments after the audit period.