DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
(617) 565-2684

November 2, 2011

Report Number: A-01-11-00524

Kathy Milovac
National Government Services, Inc.
Contract Administration, Deputy Director
8115 Knue Road
Indianapolis, IN 46205

Dear Ms. Milovac:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Outpatient Claims Processed by National Government Services, Inc., That Included Procedures for the Insertion of Multiple Units of the Same Type of Medical Device for Calendar Years 2008 and 2009.* 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.

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. 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 contact David Lamir, Audit Manager, at (617) 565-2704 or through email at David.Lamir@oig.hhs.gov. Please refer to report number A-01-11-00524 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT CLAIMS PROCESSED BY NATIONAL GOVERNMENT SERVICES, INC., THAT INCLUDED PROCEDURES FOR THE INSERTION OF MULTIPLE UNITS OF THE SAME TYPE OF MEDICAL DEVICE IN CALENDAR YEARS 2008 AND 2009

Daniel R. Levinson
Inspector General

November 2011
A-01-11-00524

Office of Inspector General

http://oig.hhs.gov

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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

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS employs Medicare contractors, including National Government Services, Inc. (NGS), to process and pay hospital outpatient claims using the Fiscal Intermediary Shared System (FISS).

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification group to which the service is assigned. Under the OPPS, outlier payments are available when exceptionally costly services exceed established thresholds.

Common medical devices implanted during outpatient procedures include cardiac devices, joint replacement devices, and prosthetics. Generally, a provider implants only one cardiac device during an outpatient surgical procedure. Under OPPS, payments to hospitals for medical devices are "packaged" into the payment for the procedure to insert the device. Hospitals are required to report the number of device units and related charges accurately on their claims. The failure to report device units and related charges accurately could result in incorrect outlier payments.

Our audit covered $273,805 in Medicare outlier payments to hospitals for 101 claims for outpatient procedures that included the insertion of more than 1 of the same type of medical device. The 101 claims had dates of service during calendar years (CY) 2008 and 2009.

OBJECTIVE

Our objective was to determine whether Medicare paid hospitals correctly for outpatient claims processed by NGS that included procedures for the insertion of multiple units of the same type of medical device.

SUMMARY OF FINDINGS

Of the 101 claims that we reviewed, Medicare paid 58 correctly for outpatient claims processed by NGS that included procedures for the insertion of multiple units of the same type of medical device. However, for the remaining 43 claims, Medicare did not pay hospitals correctly. These incorrect payments were due to hospitals overstating the number of units and related charges, resulting in excessive or unwarranted outlier payments.

For the 43 claims, NGS made overpayments to hospitals totaling $174,636. Incorrect payments occurred because hospitals had inadequate controls to ensure that they billed accurately for claims that included the insertion of medical devices. In addition, Medicare

payment controls in the FISS were not always adequate to prevent or detect incorrect payments.

RECOMMENDATIONS

We recommend that NGS:

- recover the $174,636 in overpayments for 43 inaccurate claims,
- continue to alert hospitals of the importance of coding outpatient claims with the correct number of medical device units, and
- work with CMS to strengthen FISS prepayment edits by revising the unit amount thresholds for certain medical devices.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In written comments on our draft report, NGS agreed with our findings and recommendations and outlined steps for implementing our recommendations. NGS's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

The Medicare program, established by Title XVIII of the Social Security Act (the Act), provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Part B of Title XVIII provides supplementary medical insurance for medical and other health services, including the coverage of hospital outpatient services.

CMS contracted with National Government Services, Inc. (NGS), to, among other things, process and pay claims submitted by hospital outpatient departments. NGS uses the Fiscal Intermediary Shared System (FISS) for processing hospital claims. NGS processes claims for Connecticut, Illinois, Indiana, Kentucky, Michigan, New York, Ohio, Virginia, West Virginia, and Wisconsin.

Hospital Outpatient Prospective Payment System

As mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, together with the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113, CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services. The OPPS was effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). All services and items within an APC group are comparable clinically and require comparable resources. Under the OPPS, outlier payments are available when exceptionally costly services exceed established thresholds.

Medical Devices

Common medical devices implanted during outpatient procedures include cardiac devices, joint replacement devices, and prosthetics. Generally, a provider implants only one cardiac device, such as a pacemaker or implantable cardioverter defibrillator, during an outpatient surgical procedure.

Under the OPPS, payments to hospitals for medical devices are "packaged" into the payment for the procedure to insert the device. Although separate payment is not made for the device, hospitals are still required to report device charges on their claims. Hospitals are required to report the number of device units and related charges accurately on their claims. The failure to report device units and related charges accurately could result in incorrect outlier payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare paid hospitals correctly for outpatient claims processed by NGS that included procedures for the insertion of multiple units of the same type of medical device.

Scope

Our audit covered $273,805 in Medicare outlier payments to hospitals for 101 claims for outpatient procedures that included the insertion of more than 1 of the same type of medical device. The 101 claims had dates of service during calendar years (CY) 2008 and 2009.

Our objective did not require an understanding or assessment of the complete internal control structures of hospitals or NGS. Therefore, we limited our review at hospitals to the controls related to preparing and submitting Medicare claims for procedures that included the insertion of selected medical devices. We limited our review at NGS to the controls related to preventing or detecting Medicare overpayments to hospitals for outpatient claims with overstated medical device units.

Our fieldwork included contacting NGS and the 53 hospitals that submitted the 101 claims in our review. We conducted our fieldwork from September 2010 through February 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted hospitals' outpatient paid claim data from CMS's National Claims History file for CYs 2008 and 2009;
- developed computer applications to identify outpatient claims processed by NGS that included procedures for the insertion of multiple units of the same type of medical device and identified 101 claims;
- reviewed the hospitals' itemized bills for 101 claims and selected beneficiaries' medical records to determine whether the hospitals submitted the claims with the correct device units and associated charges;
- reviewed CMS's Common Working File claims history for the 101 claims to validate the results of our computer match and to verify that the selected claims had not been canceled;

- contacted representatives of the 53 hospitals that submitted the claims to verify whether the claims were billed correctly and to determine the causes of noncompliance with Medicare billing requirements;

- contacted NGS to obtain an understanding of edits in the FISS and other controls intended to prevent or detect overpayments to hospitals;

- calculated the correct payments for claims that needed payment adjustments; and

- discussed the results of our review with NGS.

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

Of the 101 claims that we reviewed, Medicare paid 58 correctly for outpatient claims processed by NGS that included procedures for the insertion of multiple units of the same type of medical device. However, for the remaining 43 claims, Medicare did not pay hospitals correctly. These incorrect payments were due to hospitals overstating the number of units and related charges, resulting in excessive or unwarranted outlier payments.

For the 43 claims, NGS made overpayments to hospitals totaling $174,636. Incorrect payments occurred because hospitals had inadequate controls to ensure that they billed accurately for claims that included the insertion of medical devices. In addition, Medicare payment controls in the FISS were not always adequate to prevent or detect incorrect payments.

PROGRAM REQUIREMENTS

Section 1862 (a)(1)(A) of the Act states that no payment may be made under Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

The *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

Federal regulations (42 CFR §419.43 (d)) provides for outlier payments for hospital outpatient services, in addition to the prospective payment, when a hospital's charges exceed certain thresholds.

PAYMENTS BASED ON CLAIMS BILLED INCORRECTLY

Hospitals incorrectly billed medical device units for 43 of the 101 claims. These billing errors led to overstated charges, resulting in excessive or unwarranted outlier payments for 43 claims totaling $174,636.

An Example of Incorrectly Billed Units

One hospital billed for two automatic implantable cardioverter defibrillator (AICD) units with charges that totaled $185,500. However, the hospital should have billed for one AICD unit with charges of $92,750. The additional charges for the second AICD unit resulted in an unwarranted outlier payment of $8,056 to the hospital.

CAUSES OF INCORRECT PAYMENTS

Inadequate Controls at Hospitals

The 28 hospitals that received incorrect payments had not established the necessary controls to ensure that they billed the correct device units for outpatient claims processed by NGS that included procedures for the insertion of medical devices. Officials of these hospitals stated that their billing personnel had billed units incorrectly for one or more of the following reasons:

- Personnel made isolated data entry errors.
- Multiple personnel mistakenly entered the same device charges on the same claim.
- Undetected flaws in the design or implementation of some billing systems caused some claims to be submitted with multiple medical device units.

Inadequate Medicare Payment Controls

Medicare payment controls were not always adequate to prevent or detect incorrect payments. Specifically, CMS established, as part of its FISS prepayment controls, unit amount thresholds for medically unlikely edits that are too high for certain medical devices (e.g., currently, there is a two-unit threshold for pacemakers).

RECOMMENDATIONS

We recommend that NGS:

- recover the $174,636 in overpayments for the 43 inaccurate claims,

- continue to alert hospitals of the importance of coding outpatient claims with the correct number of medical device units, and

- work with CMS to strengthen FISS prepayment edits by revising the unit amount thresholds for certain medical devices.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In written comments on our draft report, NGS agreed with our findings and recommendations and outlined steps for implementing our recommendations. NGS's comments are included in their entirety as the Appendix.

APPENDIX

National Government Services

Medicare

National Government Services, Inc.
8115 Knue Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

October 17, 2011

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region I
Government Center
John F. Kennedy Federal Building
Boston, MA 02203

Report Number: A-01-11-00524

Dear Mr. Armstrong,

The following presents our response to the comments made in your report dated August 16, 2011:

Recommendation 1 - Recover the $174,636 in overpayments for the 43 inaccurate claims

We have researched the 43 claims involved. A summarization of the claim adjustments is listed below:

- A recovery in the amount of $155,930.90 has been confirmed; this represents 33 of the 43 claims.
- 1claim adjustment resulted in a payable to the provider in the amount of $364.02.
- 5 of the claims were for providers no longer serviced by NGS. These providers are in the Virginia/West Virginia workload which transitioned to a new contractor, Palmetto, GBA.
- 4 claims had not been adjusted. All necessary data to process the adjustments for these claims was received by NGS on 10/05/2011 and the adjustments were initiated. As of today, 10/06/2011 the claims are at CWF. We will provide an updated spreadsheet with the recovery amounts upon finalization and recovery.

Recommendation 2 – Continue to alert hospitals of the importance of coding outpatient claims with the correct number of medical device units

Provider Outreach & Education will offer Live and In Person sessions and expanding our discussion points for currently planned education on the hemophilia clotting factor. This education is starting immediately and will continue with webinars, etc. throughout the coming year. This topic is also being added to the NGS hospital SME team's education plan.

NOTE: There are Virginia and West Virginia providers included in the review that will need to go to PGBA since this workload transitioned in April 2011.

Recommendation 3 – Work with CMS to strengthen FISS prepayment edits revising the unit amount thresholds for certain medical devices

National Government Services is verifying that edits are in place to ensure unit amount thresholds are in place. Any unit thresholds that are not in place will be implemented. With research completed, it has been

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

confirmed that all the codes identified have an established number of maximum units and they are being checked on FISS. If the claim exceeds the maximum number of allowable units, the claim will be rejected. All of the codes that caused the claims identified on this audit to pay incorrectly are now being monitored to prevent a higher than allowable number of units to be paid.

Sincerely yours,
/s/ Barbie Williams

Barbie Williams,
Director NGS Operations Excellence