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

February 10, 2012

Report Number: A-01-11-00532

Ms. Jared A. Adair
Senior Vice President, Medicare Division
Wisconsin Physicians Service
1717 W. Broadway
P.O. Box 8190
Madison, WI 53708

Dear Ms. Adair:

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 Wisconsin Physicians Service That Included Procedures for the Insertion of Multiple Units of the Same Type of Medical Device in 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 Kimberly Rapoza, Audit Manager, at (617) 565-2695 or through email at Kimberly.Rapoza@oig.hhs.gov. Please refer to report number A-01-11-00532 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, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT CLAIMS PROCESSED BY WISCONSIN PHYSICIANS SERVICE 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

February 2012
A-01-11-00532

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 Wisconsin Physicians Service (WPS), 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 assigned ambulatory payment classification group. 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 infusion pumps. Generally, a provider implants only one cardiac device during an outpatient surgical procedure. Under the OPPS, payments to hospitals for medical devices are "packaged" into the payments for the procedures to insert devices. 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 $32,860 in Medicare outlier payments to hospitals for 14 claims for outpatient procedures that included the insertion of more than 1 of the same type of medical device. The 14 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 WPS that included procedures for the insertion of multiple units of the same type of medical device.

SUMMARY OF FINDINGS

Of the 14 claims that we reviewed, Medicare paid 8 correctly for outpatient claims processed by WPS that included procedures for the insertion of multiple units of the same type of medical device. However, for the remaining six 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 six claims, WPS made overpayments to hospitals totaling $17,996. 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 WPS:

- recover the $17,996 in overpayments for six 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.

WISCONSIN PHYSICIANS SERVICE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, WPS agreed with our recommendations and described its corrective actions. WPS's recovery of overpayments was greater than the recovery amount that we recommended in our draft report because of changes made by one hospital in the resubmission of its claim. Therefore, we have updated this report to reflect the actual overpayment amount.

WPS's comments are included in their entirety as the Appendix.

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WISCONSIN PHYSICIANS SERVICE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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 Wisconsin Physicians Service (WPS), to, among other things, process and pay claims submitted by hospital outpatient departments. WPS uses the Fiscal Intermediary Shared System (FISS) for processing hospital claims. WPS processes claims for Iowa, Kansas, Missouri, and Nebraska.

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, and infusion pumps. 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 payments for the procedures to insert devices. Although separate payments are not made for devices, 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 WPS that included procedures for the insertion of multiple units of the same type of medical device.

Scope

Our audit covered $32,860 in Medicare outlier payments to hospitals for 14 claims for outpatient procedures that included the insertion of more than 1 of the same type of medical device. The 14 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 the hospitals or WPS. 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 WPS to the controls related to preventing or detecting Medicare overpayments to hospitals for outpatient claims with overstated medical device units.

Our fieldwork included contacting WPS and the 10 hospitals that submitted the 14 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 WPS that included procedures for the insertion of multiple units of the same type of medical device and identified 14 claims to review;
- reviewed the hospitals' itemized bills for 14 claims and selected beneficiaries' medical records to determine whether the hospitals submitted claims with the correct device units and associated charges;
- reviewed CMS's Common Working File claims history for the 14 claims to validate the results of our computer match and to verify that the selected claims had not been canceled;

- contacted representatives of the 10 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 WPS 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 WPS.

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 14 claims that we reviewed, Medicare paid 8 correctly for outpatient claims processed by WPS that included procedures for the insertion of multiple units of the same type of medical device. However, for the remaining six 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 six claims, WPS made overpayments to hospitals totaling $17,996. 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 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 Section 419.43(d)) provide 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 6 of the 14 claims. These billing errors led to overstated charges, resulting in excessive or unwarranted outlier payments for six claims totaling $17,996.

An Example of Incorrectly Billed Units

> One hospital billed for two automatic implantable cardioverter defibrillator (AICD) units with charges that totaled $124,470. However, the hospital should have billed for one AICD unit with charges of $62,235. The additional charges for the second AICD unit resulted in an unwarranted outlier payment of $3,618 to the hospital.

CAUSES OF INCORRECT PAYMENTS

Inadequate Controls at Hospitals

The four 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 WPS that included procedures for the insertion of medical devices. Officials of these hospitals stated that their billing personnel had billed units incorrectly because they made isolated data entry errors.

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., there is a two-unit threshold for pacemakers).

RECOMMENDATIONS

We recommend that WPS:

- recover the $17,996 in overpayments for six 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.

WISCONSIN PHYSICIANS SERVICE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, WPS agreed with our recommendations and described its corrective actions. WPS's recovery of overpayments was greater than the recovery amount that we recommended in our draft report because of changes made by one hospital in the resubmission of its claim. Therefore, we have updated this report to reflect the actual overpayment amount.

WPS's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: WISCONSIN PHYSICIANS SERVICE COMMENTS

Medicare

January 11, 2012

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

RE: Office of Inspector General (OIG) Draft Report – A-01-11-00532

Dear Mr. Armstrong,

This letter is in response to the OIG draft report titled *Review of Outpatient Claims Processed by Wisconsin Physicians Service That Included Procedures For The Insertion of Multiple Units of the Same Type of Medical Device in Calendar Years 2008 and 2009.* Per the OIG's request we are submitting this revised response letter (originally submitted November 21, 2011) to the draft report to incorporate the results of a provider adjustment that occurred subsequent to our initial responses.

OIG reviewed fourteen Medicare Part A outpatient claims processed by Wisconsin Physicians Service (WPS) that included procedures for the insertion of multiple units of the same type of medical device. Of these, six claims were identified as improper payments needing action, totaling $15,308. The OIG report stated the *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.*

OIG Recommendations to WPS:

- *recover the $15,308 in overpayments for six 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*

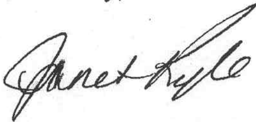
WPS Response to the OIG Recommendations:

- WPS should *recover the $15,308 in overpayments for six inaccurate claims*
  - The six identified claims have been adjusted for an overpayment of $17,995.84, which has been fully recovered.
- WPS should *continue to alert hospitals of the importance of coding outpatient claims with the correct number of medical device units, and*
  - WPS' current Outpatient Prospective Payment System (OPPS) education includes information on correct coding of devices and units. The next OPPS education presentations are tentatively scheduled for April 1, 2012 in Arlington Height, Illinois and Kansas City, Missouri at a date yet to be determined. In addition, WPS is developing a website "Message Box Tip" reminder on correct coding of units.

- WPS should *work with CMS to strengthen FISS prepayment edits by revising the unit amount thresholds for certain medical devices*
  - o WPS will work with CMS to strengthen FISS prepayment edits by requesting a revision to the unit amount thresholds for certain medical devices. We recommend that CMS issue instruction to the system maintainer to hard code the edits to ensure consistency among all contractors.
  - o WPS staff will work with our Contract Medical Director to review the list of device Healthcare Common Procedure Codes (HCPCs) and determine if adequate CMS policy exists to implement edits to Return To Provider (RTP) those claims that bill in excess of allowable units.

If you have any questions or would like to set up a time for a conference call to discuss any issues identified in your report and/or the WPS response, please contact Mark DeFoil of my staff at 402-995-0443.

Sincerely,



Janet Kyle
Vice President, Program Management

cc: John Phelps, CMS
Lisa Goschen, CMS
Kimberly Rapoza, OIG