October 3, 2011

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

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Select Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 13 for the Period January 1, 2006, Through June 30, 2009 (A-02-10-01008)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by National Government Services (NGS) in Jurisdiction 13. We will issue this report to NGS within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through email at James.Edert@oig.hhs.gov. Please refer to report number A-02-10-01008.

Attachment

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

Office of Audit Services
Jacob Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

October 5, 2011

Report Number: A-02-10-01008

Mr. Scott Kimbell
Jurisdiction 13 Program Director
National Government Services
9901 Linn Station Road
Louisville, KY 40223

Dear Mr. Kimbell:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Select Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 13 for the Period January 1, 2006, Through June 30, 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 Jeffrey I. Jacobs, Audit Manager, at (212) 264-1321 or through email at Jeffrey.Jacobs@oig.hhs.gov. Please refer to report number A-02-10-01008 in all correspondence.

Sincerely,

/James P. Edert/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. 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 SELECT MEDICARE PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY NATIONAL GOVERNMENT SERVICES IN JURISDICTION 13 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

October 2011
A-02-10-01008

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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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

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with Medicare contractors to process and pay Medicare claims submitted for outpatient services. The Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered. In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

In March 2008, National Government Services (NGS) was awarded the Medicare administrative contractor contract for Jurisdiction 13, which includes the States of Connecticut and New York. During our audit period (January 2006 through June 2009), approximately 197 million line items for outpatient services were processed in Jurisdiction 13, of which 1,903 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service. (A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges.") We reviewed only 1,841 of these line items because 8 providers associated with 62 line items were no longer in business or were in bankruptcy.

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges that NGS made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 1,841 selected line items for which NGS made Medicare payments to providers for outpatient services during our audit period, 530 were correct. The remaining 1,311 line items were incorrect and included overpayments totaling $7,676,440.

Of the 1,311 incorrect line items:

- Providers reported incorrect units of service on 1,086 line items, resulting in overpayments totaling $6,798,653.

- Providers used HCPCS codes that did not reflect the procedures performed on 76 line items, resulting in overpayments totaling $320,487.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 51 line items, resulting in overpayments totaling $276,297.

- Providers billed for services not supported by documentation for 94 line items, resulting in overpayments totaling $270,896.

- Providers billed for services with an incorrect payment rate for four line items, resulting in overpayments totaling $10,107.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that NGS:

- recover the $7,676,440 in identified overpayments,

- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and

- use the results of this audit in its provider education activities.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, NGS generally agreed with our first recommendation and stated that it would review the claims detailed in our audit to recover overpayments. Citing limitations within CMS's Part A processing system, NGS stated that our second recommendation to implement system edits would "require additional clarification and discussion." Finally,

regarding our third recommendation (provider education activities), NGS stated that it would research the issues that we identified in our report and indicated steps that it planned to take to educate providers on potential billing errors. NGS's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We encourage NGS to implement system edits to the extent possible under its current contract with CMS.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted for outpatient services.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process providers' outpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.[2] In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

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[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 between October 2005 and October 2011. Most, but not all, of the Medicare administrative contractors are fully operational; for jurisdictions where the Medicare administrative contractors are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or Medicare administrative contractors, whichever is applicable.

[2] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

National Government Services

In March 2008, National Government Services (NGS) was awarded the Medicare administrative contractor (MAC) contract for Jurisdiction 13, which includes the States of Connecticut and New York. [3] During our audit period (January 2006 through June 2009), approximately 197 million line items for outpatient services were processed in Jurisdiction 13.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges that NGS made to providers for outpatient services were correct.

Scope

Of the approximately 197 million line items for outpatient services that NGS processed during the period January 2006 through June 2009, 1,903 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service.[4] We reviewed only 1,841 of these line items because 8 providers associated with 62 line items were no longer in business or were in bankruptcy.

We limited our review of NGS's internal controls to those that were applicable to the selected payments because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

Our fieldwork included contacting NGS in Louisville, Kentucky, and the 155 providers in Jurisdiction 13 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[3] Prior to the award and implementation of the contract, providers processed Medicare outpatient claims through separate fiscal intermediaries. In November 2008, NGS assumed full responsibility for the work in Jurisdiction 13. Therefore, NGS is responsible for collecting any overpayments and resolving the issues related to this audit.

[4] A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges."

- used CMS's National Claims History file to identify 2,345 outpatient line items, totaling $24.8 million, in which (1) Medicare line payment amounts exceeded the line billed charge amounts by at least $1,000 and (2) the line item had 3 or more units of service;

- excluded from our review 442 line items, totaling $4.4 million, that were adjusted prior to the start of fieldwork and resulted in line payment amounts that exceeded line charges by $1,000 or less;

- contacted the 155 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;

- excluded from our review 62 line items, totaling $372,450, made to 8 providers that were no longer in business or were in bankruptcy;

- reviewed 1,841 line items, totaling $20 million, that Medicare paid to 147 providers;

- reviewed documentation, if any, that these providers furnished to verify whether each selected line item was billed correctly;

- coordinated the calculation of overpayments with NGS; and

- discussed the results of our review with NGS officials on April 12, 2011.

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 1,841 line items reviewed for which NGS made Medicare payments to providers for outpatient services during our audit period, 530 were correct. The remaining 1,311 line items were incorrect and included overpayments totaling $7,676,440.

Of the 1,311 incorrect line items:

- Providers reported incorrect units of service on 1,086 line items, resulting in overpayments totaling $6,798,653.

- Providers used HCPCS codes that did not reflect the procedures performed on 76 line items, resulting in overpayments totaling $320,487.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 51 line items, resulting in overpayments totaling $276,297.

- Providers billed for services not supported by documentation for 94 line items, resulting in overpayments totaling $270,896.

- Providers billed for services with an incorrect payment rate for four line items, resulting in overpayments totaling $10,107.

The providers attributed the incorrect payments to clerical errors or to provider billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect these overpayments.

FEDERAL REQUIREMENTS

Section 1833(e) of the Social Security Act states: "No payment shall be made to any provider of services … unless there has been furnished such information as may be necessary in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …."

CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: "providers must use HCPCS codes … for most outpatient services." Chapter 25, section 75.5, of the Manual states: "when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed." [5] If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 …."

Chapter 1, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported incorrect units of service on 1,086 line items, resulting in overpayments totaling $6,798,653. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for 31 line items with the administered drug dosage listed as the units of service provided. The provider stated that it did not convert the dosage administered to billable units before submitting the claim to Medicare. As a result of this error, NGS paid the provider $666,241 when it should have paid $58,939, an overpayment of $607,302.

[5] Before CMS Transmittal 1254, Change Request 5593, dated May 25, 2007, and effective June 11, 2007, this provision was located at chapter 25, section 60.5, of the Manual.

- One provider billed Medicare for 15 line items for various types of incorrect service units, such as billing for the total minutes of operating room time as the units of service provided. The provider stated that these were clerical errors. As a result of these errors, NGS paid the provider $85,274 when it should have paid $9,457, an overpayment of $75,817.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 76 line items, resulting in overpayments totaling $320,487. For example, a provider billed Medicare for 12 line items with an HCPCS code for a drug used to dissolve blood clots rather than the iron sucrose administered to replenish the patient's iron during dialysis treatments. As a result of these errors, NGS paid the provider $86,486 when it should have paid $981, an overpayment of $85,505.

Combination of Incorrect Number of Units of Service and Incorrect Healthcare Common Procedure Coding System Codes

Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 51 line items. These errors resulted in overpayments totaling $276,297. For example, a provider billed Medicare for five line items with incorrect units of a drug and the incorrect HCPCS for the vial size used during the administration of the drug. As a result of these errors, NGS paid the provider $10,279 when it should have paid $70, an overpayment of $10,209.

Unsupported Services

Providers billed Medicare for 94 line items for which the providers did not provide sufficient supporting documentation, resulting in overpayments totaling $270,896.[6] For example, one provider billed Medicare on 10 line items for drugs that were not documented as having been administered. As a result of these errors, NGS paid the provider $26,277 when it should have paid $0, an overpayment of $26,277.

Incorrect Payment Rates

Providers billed Medicare for services with an incorrect payment rate for four line items, resulting in overpayments totaling $10,107. For example, one provider improperly billed Medicare, as an outpatient service, one line item for seven units of a blood transfusion administered to a patient during an inpatient procedure. As a result of this error, NGS improperly paid the provider $1,446 when it should have paid $0, an overpayment of $1,446.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System

[6] For 60 line items, providers did not provide any documentation for review.

nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.[7]

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires Medicare contractors to determine the legitimacy of the claims. However, this edit did not detect the errors that we found because the edit considers only the amount of the payment, suspends only those payments that exceed the threshold, and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that NGS:

- recover the $7,676,440 in identified overpayments,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, NGS generally agreed with our first recommendation and stated that it would review the claims detailed in our audit to recover overpayments. Citing limitations within CMS's Part A processing system, NGS stated that our second recommendation to implement system edits would "require additional clarification and discussion." Finally, regarding our third recommendation (provider education activities), NGS stated that it would research the issues that we identified in our report and indicated steps that it planned to take to educate providers on potential billing errors.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

We encourage NGS to implement system edits to the extent possible under its current contract with CMS.

[7] The Medicare contractor sends a *Medicare Summary Notice*—an explanation of benefits—to the beneficiary after the provider files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX

APPENDIX: NATIONAL GOVERNMENT SERVICES COMMENTS

Medicare

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

August 12, 2011

Mr. James P. Edert
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region II
Jacob Javits Federal Building
26 Federal Plaza – Room 3900
New York, NY 10278

Report Number: A-02-10-01008

Dear Mr. Edert,

The following presents our response to the comments made in your report dated July 15, 2011:

Recommendation 1 - Recover the $7,676,440 in identified overpayments
Based on the findings provided of the claim detail, NGS will review each case and work accordingly to recover the amounts due to the program upon final determination.

Recommendation 2 - Implement system edits that identify line item payments that exceed billed charges by a prescribed amount

Upon further review of this recommendation, the requested edits will require additional clarification and discussion. Due to system limitations within the CMS Part A processing system, it is unclear how a comparison may be made prior to moving through the Pricer. Financial calculations are completed once the claim is stored and ready to send to CWF.

There is a possibility to suspend certain APC or DRG, however, a manual review of many claims would have to be completed. This type of edit would create significant additional workload.

If particular revenue codes or HCPC codes were identified in this review, National Government Services could set up an edit to suspend those meeting predetermined criteria for units and/or amount billed. This effort would result in a smaller additional manual effort to set up, test, and move to production. Once in production, there would need to be a prescribed review, either local or national, to maintain this edit for any needed updates.

Further consideration is respectfully being requested with regards to this recommendation.

Recommendation 3 - Use the results of this audit in its provider education activities

Provider Outreach and Education (POE) will research the issues identified within the report and the reasons stated by the Connecticut and New York providers as reasons for the incorrect overpayments. POE will provide ongoing education via the National Government Services web site and listserv notices to the Connecticut and New York providers regarding outpatient claim errors. POE will monitor data for trends,

utilization patterns, denials and provide web articles and list serves where high denials have been identified for outpatient services.

Sincerely yours,

/Barbie Williams/

Barbie Williams,
Director NGS Operations Excellence