November 28, 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 Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services but Transitioned to Palmetto GBA, LLC, in Jurisdiction 11 for the Period January 1, 2006, Through June 30, 2009 (A-03-10-00005)

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 but transitioned to Palmetto, GBA, LLC (Palmetto), in Jurisdiction 11. We will issue this report to Palmetto 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 Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-10-00005.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

November 30, 2011

Report Number: A-03-10-00005

Mr. Bruce Hughes
President and Chief Operating Officer
Palmetto GBA, LLC
P.O. Box 100134
Columbia, SC 29202

Dear Mr. Hughes:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services but Transitioned to Palmetto GBA, LLC, in Jurisdiction 11 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 at (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through email at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-10-00005 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

cc:
Mr. Neal Burkhead
Vice President
J11 AB MAC Operations

Ms. Yvonna Ruff
Director
Part A Claims

National Government Services Medicare

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 MEDICARE PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY NATIONAL GOVERNMENT SERVICES BUT TRANSITIONED TO PALMETTO GBA, LLC, IN JURISDICTION 11 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

November 2011
A-03-10-00005

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:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

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.

Before May 16, 2011, National Government Services (NGS) was the Medicare fiscal intermediary for Virginia and West Virginia. From January 2006 through June 2009, NGS processed approximately 92 million line items for outpatient services, of which 942 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.")

On May 21, 2010, CMS announced that Palmetto GBA, LLC (Palmetto), had been awarded the contract as the Medicare administrative contractor for Jurisdiction 11 in four States: North Carolina, South Carolina, Virginia, and West Virginia. For Virginia and West Virginia providers, the effective date for transferring from NGS to Palmetto was May 16, 2011. Because Palmetto has assumed responsibility for claims paid by NGS, we have addressed our findings and recommendations to Palmetto for review and comment.

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 942 selected line items for which NGS made Medicare payments to providers for outpatient services during our audit period, 162 were correct. Providers refunded overpayments on 85 line items totaling $317,979 before our fieldwork. The remaining 695 line items were incorrect and included overpayments totaling $5,245,248 that the providers had not refunded by the beginning of our audit.

Of the 695 incorrect line items:

- Providers reported incorrect units of service on 464 line items, resulting in overpayments totaling $4,330,829.
- Providers did not provide supporting documentation for 91 line items, resulting in overpayments totaling $328,670.
- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 72 line items, resulting in overpayments totaling $297,570.
- Providers billed separately for services on 47 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling $209,268.
- Providers used incorrect HCPCS codes on seven line items, resulting in overpayments totaling $34,920.
- Providers billed for unallowable services or drugs on nine line items, resulting in overpayments totaling $30,313.
- A provider billed for the unlabeled use of a drug/biological on five line items, resulting in overpayments totaling $13,678.

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 Palmetto:

- recover the $5,245,248 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.

PALMETTO GBA, LLC, COMMENTS

In written comments on our draft report, Palmetto generally concurred with our findings and recommendations and described corrective actions that it had taken or planned to take. Palmetto's comments are included in their entirety as the Appendix.

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.

[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 (MAC) 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. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

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

National Government Services and Palmetto GBA, LLC

Before May 16, 2011, National Government Services (NGS) was the Medicare fiscal intermediary for Virginia and West Virginia. From January 2006 through June 2009, NGS processed approximately 92 million line items for outpatient services.

On May 21, 2010, CMS announced that Palmetto GBA, LLC (Palmetto), had been awarded the contract as the MAC for Jurisdiction 11 in four States: North Carolina, South Carolina, Virginia, and West Virginia. For Virginia and West Virginia providers, the effective date for transferring from NGS to Palmetto was May 16, 2011. Because Palmetto has assumed responsibility for claims paid by NGS, we have addressed our findings and recommendations to Palmetto for review and comment.

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 92 million line items for outpatient services that NGS processed during the period January 2006 through June 2009, 942 line items totaling $6,748,910 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.[3]

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.

This report includes all items with payments for line items that exceeded the billed charges by at least $1,000. We will report the results of our review of all items with payments for line items that exceeded billed charges by $500 to $1,000 separately in report number A-03-11-00005.

Our fieldwork included contacting NGS in Indianapolis, Indiana, and the 62 providers in Virginia and West Virginia that received the selected Medicare payments.

[3] 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."

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items 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;[4]
- identified 942 line items, totaling $6,748,910, that Medicare paid to 62 providers;
- contacted the 62 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;
- reviewed documentation that the 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 on May 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 942 selected line items for which NGS made Medicare payments to providers for outpatient services during our audit period, 162 were correct. Providers refunded overpayments on 85 line items totaling $317,979 before our fieldwork. The remaining 695 line items were incorrect and included overpayments totaling $5,245,248 that the providers had not refunded by the beginning of our audit.

Of the 695 incorrect line items:

- Providers reported incorrect units of service on 464 line items, resulting in overpayments totaling $4,330,829.
- Providers did not provide supporting documentation for 91 line items, resulting in overpayments totaling $328,670.

[4] For this audit, we reviewed those line items that met the stated parameters. We applied those parameters to unadjusted line items. In some cases, subsequent payment adjustments reduced the difference between payments and charges to less than $1,000.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 72 line items, resulting in overpayments totaling $297,570.

- Providers billed separately for services on 47 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling $209,268.

- Providers used incorrect HCPCS codes on seven line items, resulting in overpayments totaling $34,920.

- Providers billed for unallowable services or drugs on nine line items, resulting in overpayments totaling $30,313.

- A provider billed for the unlabeled use of a drug/biological on five line items, resulting in overpayments totaling $13,678.

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.

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." 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 464 line items, resulting in overpayments totaling $4,330,829. These overpayments occurred primarily for two reasons:

- Forty-one providers billed Medicare for 296 line items with incorrect service units involving 48 different drugs, biologicals,[5] and blood products. Rather than billing between 1 and 2,431 service units, providers billed between 5 and 10,000 service units. These errors occurred because of human error or because the provider's chargemaster[6] was incorrect. As a result of these errors, NGS paid the 41 providers a total of $4,257,632 when it should have paid $428,744, an overpayment of $3,828,888.

- Twenty-five providers billed Medicare for 82 line items with an incorrect number of surgical procedures performed. Rather than billing for the number of surgical procedures performed, providers either billed the wrong number of procedures or billed for the units of time (e.g., minutes, quarter-hours, and hours) spent in the surgical suite. For each of the 82 cases, the provider performed between 1 and 3 surgical procedures but billed for between 3 and 100 services. As a result of these errors, NGS paid the 25 providers a total of $421,170 when it should have paid $77,461, an overpayment of $343,709.

Unsupported Services

Seventeen providers billed Medicare for 91 line items for which the providers did not provide supporting documentation. The providers agreed to cancel the claims associated with these line items or file adjusted claims and refund the combined $328,670 in overpayments that they received.

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 72 line items. These errors resulted in overpayments totaling $297,570. The following examples illustrate the combination of incorrect number of units of service claimed and incorrect HCPCS codes used:

- One provider billed Medicare for between 12 and 200 units of Baclofen injection (HCPCS code J0475, 10 mg/unit). However, the provider should have billed for between 10 and 60 units of Baclofen intrathecal trial (HCPCS code J0476, 50 mcg/unit), the dose actually administered. Similar errors occurred on a total of 17 line items that this provider submitted. As a result of these errors, NGS paid the provider $137,170 when it should have paid $54,082, an overpayment of $83,088.

- Another provider billed Medicare for a procedure with 10 units of service for "platelets, pheresis" (HCPCS code P9034). However, the provider should have billed for two units of "platelets, pheresis, leukocytes reduced, cmv-negative, irradiated" (HCPCS code P9053). Similar errors occurred on a total of 24 line items that this provider submitted.

[5] Biologicals are substances made from a living organism or its products that are used to prevent, diagnose, treat, or relieve symptoms of a disease.

[6] A provider's chargemaster contains data on every chargeable item or procedure that the provider offers, including a factor that converts a drug's dosage to the number of units to bill.

As a result of these errors, NGS paid the provider a total of $56,744 when it should have paid $21,209, an overpayment of $35,535.

Payment for Packaged Services

Eleven providers billed Medicare on 47 line items for services that were not separately payable by Medicare. These services were billed as separately payable drugs but were actually ordinary pharmacy drugs that were packaged in the payment for the primary procedure. These errors resulted in overpayments totaling $209,268. For example, 2 providers billed Medicare for 28 line items for the lipid formulation of doxorubicin hydrochloride (HCPCS code J9001), but the drug actually administered was the nonlipid formulation of doxorubicin hydrochloride (HCPCS code J9000). During the dates of service on which the providers administered this drug, Medicare included the nonlipid formulation in the payment for related chemotherapy and did not provide for separate reimbursement under the outpatient prospective payment system. As a result of these errors, NGS incorrectly paid the provider $84,499.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used incorrect HCPCS codes for seven line items, resulting in overpayments totaling $34,920. The following examples illustrate the use of incorrect HCPCS codes:

- Two providers billed Medicare for 2 line items for 16 units of service with an incorrect HCPCS code (HCPCS codes 42405 and J2505) because of keying errors. The provider should have billed for 16 units of Ondansetron hydrochloride injection (HCPCS code J2405), the drug actually administered. As a result of these errors, NGS paid the provider $12,671 when it should have paid $48, an overpayment of $12,623.

- One provider billed Medicare for 1 line item for 100 units of service of chemo IV infusion (HCPCS code 96413). However, the provider should have billed for 100 units of Darbepoetin alfa (HCPCS code J0881), the drug actually administered. As a result of this error, NGS paid the provider $11,361 when it should have paid $310, an overpayment of $11,051.

Services Not Allowable for Medicare Reimbursement

Providers billed Medicare for nine line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling $30,313. These overpayments occurred primarily because four providers billed Medicare for seven line items for dental procedures that were not covered outpatient services. According to the *Medicare Benefit Policy Manual* (Pub. No. 100-02, chapter 15, section 150), "items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered" by Medicare, unless the dental procedure is an integral part of another procedure covered by Medicare. None of the seven dental services billed was an integral part of another covered procedure. As a result of these errors, NGS incorrectly paid the providers $27,365.

Unlabeled Use of a Drug/Biological

One provider billed Medicare for the unlabeled use of the biological Retavase for five line items, resulting in overpayments totaling $13,678. Retavase is approved by the Food and Drug Administration (FDA) to treat cardiac conditions using a single-use dose (18.1 mg). However, the provider split a single labeled dose into 25 separate "mini" doses and used each mini dose as a thrombolytic[7] agent to clean dialysis patient catheters. The provider then billed Medicare for a full single-use dose of Retavase for each mini dose administered. According to the *Medicare Benefit Policy Manual* (Pub. No. 100-02, chapter 15, section 50.4.2):

> An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice.… These decisions are made by the contractor on a case-by-case basis. [Emphasis added.]

Providers must identify on their claims that the billed service was for the unlabeled use of a drug or biological.[8] However, the provider submitted these line items as if the single-use dose had been administered for the labeled use. Consequently, NGS did not know that the five line items were for an unlabeled use that required a case-by-case payment determination and incorrectly paid the provider $13,678.

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 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.[9]

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.

---

[7] The *Medicare Claims Processing Manual*, Pub. No. 100-4, chapter 8, section 60.2.1.1, identifies "thrombolytics: used to declot central venous catheters" as a separately billable drug used to treat a patient's renal condition.

[8] Providers should indicate the unlabeled use of a drug or biological in the remarks section of the claim.

[9] 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.

RECOMMENDATIONS

We recommend that Palmetto:

- recover the $5,245,248 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.

PALMETTO GBA, LLC, COMMENTS

In written comments on our draft report, Palmetto generally concurred with our findings and recommendations and described corrective actions that it had taken or planned to take. Palmetto's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: PALMETTO GBA, LLC, COMMENTS

Palmetto GBA℠
PARTNERS IN EXCELLENCE℠

Bruce W. Hughes
President and Chief Operating Officer

October 27, 2011

Stephen Virbitsky
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Reference: Draft Report No. A-03-10-00005

Dear Mr. Virbitsky:

This letter is in response to the recent Office of Inspector General (OIG) report entitled "*Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services, in Jurisdiction 11 for the Period January 1, 2006 Through June 30, 2009"*, addressed to Bruce Hughes. We appreciate the feedback your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

As stated in the report, Palmetto GBA, LLC (Palmetto) assumed full responsibility as the Medicare Administrative Contractor (MAC) for Jurisdiction 11 effective June 2011. During the audit period approximately 942 line items were selected which had:

(1) a Medicare line payment amount that exceeded the line billed charge of $1,000
(2) an incorrect unit of service
(3) a combination of incorrect units of service and incorrect HCPCS
(4) no supporting documentation provided
(5) separate billing for packaged services
(6) billing for unallowable services
(7) use of incorrect HCPCS codes
(8) billing for unlabeled use of a drug/biological

Of the 942 selected line items for which Medicare made payments to providers for outpatient services during the audit period, 162 were correct. Providers refunded overpayments on 85 line items totaling $317,979 before fieldwork. The remaining 695 line items were incorrect. Thus the following recommendations:

- **Recover the $5,245,248 identified overpayments.**

  Palmetto GBA Response:
  All claims identified in the audit are adjusted for payment recovery and completed as of October 24, 2011.

- **Implement system edits that review line item payments that exceed billed charges by a prescribed amount.**

Palmetto GBA Response:
Palmetto GBA has implemented Medically Unlikely Edits (MUEs), Maximum Allowed Units (MAUs), and exclusion edits (e.g. dental, cosmetic).

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

  Palmetto GBA Response:
  - Correct coding has been and continues to be discussed in each educational session.
  - Drugs and Biologicals Webinars instruct providers to identify drugs and biologicals with appropriate HCPCS codes.
  - In the Drugs and Biologicals Webinar providers are instructed to identify drugs and biologicals with appropriate HCPCS codes and appropriate numbers of units.
  - Billing for unallowable services is and will continue to be discussed in CERT education and Top 10 Claim Submission Errors educational presentations.
  - Our recent CERT/Claim Submission Errors One-on-One sessions focused on documentation and improper payments.
  - Additional 2011 and 2012 provider outreach and education events include seminars and workshops on:
    - Claims Submission Errors
    - Billing and Coding
    - Part B of A Small and New Provider Billing Training
    - CERT
    - Top Denials and Inquiries.

In addition, Palmetto GBA will address claims submission errors on a quarterly basis in our Ask the Contractor teleconferences and monthly meetings with hospital Compliance Officers to increase awareness.

Thank you for providing Palmetto GBA with the opportunity to offer feedback regarding your review. If you have any questions, please do not hesitate to contact me.

Sincerely

/BRUCE HUGHES/

cc: Steven Smetak, COTR, CMS
Daniel Dion, CMS
Ann Archibald, Palmetto GBA
Mike Barlow, Palmetto GBA
Robin Spires, Palmetto GBA
Sheri Thompson, Palmetto GBA