DEPARTMENT OF HEALTH & 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

August 12, 2011

Report Number: A-03-11-00004

Mr. Patrick Kiley
President
Highmark Medicare Services
1800 Center Street
Camp Hill, PA 17011

Dear Mr. Kiley:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges By $500 to $1,000 for Outpatient Services Processed by Highmark Medicare Services in Jurisdiction 12 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 J. Siegel, Audit Manager, at (215) 861-4484 or through email at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-11-00004 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

cc: Mr. David Vaughn, Vice President, Operations
Ms. Laura Minter, Program Manager, MAC Jurisdiction 12
Mr. E. James Bylotas, Director, Quality & Performance Management

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 BY $500 TO $1,000 FOR OUTPATIENT SERVICES PROCESSED BY HIGHMARK MEDICARE SERVICES IN JURISDICTION 12 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

August 2011
A-03-11-00004

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.

Effective October 2007, Highmark Medicare Services (Highmark) became the Medicare contractor for Jurisdiction 12 in five States. During our audit period (January 2006 through June 2009), approximately 242 million line items for outpatient services were processed in Jurisdiction 12, of which 748 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by between $500 and $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 739 of these line items because 6 providers associated with 9 line items were either no longer in business or included in other reviews.

OBJECTIVE

Our objective was to determine whether Medicare payments in excess of charges by $500 to $1,000 that Highmark made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 739 selected line items for which Highmark made Medicare payments to providers for outpatient services during our audit period, 280 were correct. Providers refunded overpayments on 41 line items totaling $31,179 prior to our fieldwork. The remaining 418 line items were

incorrect and included overpayments totaling $531,797 that the providers had not refunded by the beginning of our audit.

Of the 418 incorrect line items:

- Providers reported incorrect units of service on 343 line items, resulting in overpayments totaling $435,099.

- Providers did not provide supporting documentation for 26 line items, resulting in overpayments totaling $31,005.

- Providers billed for unallowable services on nine line items, resulting in overpayments totaling $19,257.

- Providers billed separately for services on 18 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling $18,722.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on nine line items, resulting in overpayments totaling $11,600.

- Providers used incorrect HCPCS codes on 11 line items, resulting in overpayments totaling $10,766.

- One provider billed for the unlabeled use of a drug/biological on one line item, resulting in an overpayment totaling $3,657.

- Highmark incorrectly calculated the payment for one line item that resulted in an overpayment of $1,691.

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. Highmark 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 Highmark:

- recover the $531,797 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.

HIGHMARK MEDICARE SERVICES COMMENTS

In written comments on our draft report, Highmark generally concurred with our findings and recommendations and described corrective actions that it had taken or planned to take. Highmark'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.

Highmark Medicare Services

Effective October 2007, Highmark Medicare Services (Highmark) became the Medicare administrative contractor for Jurisdiction 12 in five States: Delaware, the District of Columbia, Maryland, New Jersey, and Pennsylvania.[3] From January 2006 through June 2009, approximately 242 million line items for outpatient services were processed in Jurisdiction 12.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare payments in excess of charges by $500 to $1,000 that Highmark made to providers for outpatient services were correct.

Scope

Of the approximately 242 million line items for outpatient services that Highmark processed during the period January 2006 through June 2009, 748 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount between $500 and $1,000 and (2) 3 or more units of service.[4] We reviewed only 739 of these line items because 6 providers associated with 9 line items were either no longer in business or included in other reviews.

We limited our review of Highmark'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 billed charges by $500 to $1,000. We will report the results of our review of all items with payments for line items that exceeded billed charges by at least $1,000 separately in report number A-03-10-00004.

Our fieldwork included contacting Highmark in Camp Hill, Pennsylvania, and the 125 providers in Jurisdiction 12 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[3] Before October 24, 2007, providers processed Medicare outpatient claims through separate fiscal intermediaries. On October 24, 2007, Highmark became the Medicare administrative contractor for these States and is therefore 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 outpatient line items in which (1) Medicare line payment amounts exceeded the line billed charge amounts between $500 and $1,000 and (2) the line item had 3 or more units of service;[5]

- identified 739 line items, totaling $1,232,239, that Medicare paid to 125 providers;

- contacted the 125 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 Highmark; and

- discussed the results of our review with Highmark on March 1, 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 739 selected line items for which Highmark made Medicare payments to providers for outpatient services during our audit period, 280 were correct. Providers refunded overpayments on 41 line items totaling $31,179 prior to our fieldwork. The remaining 418 line items were incorrect and included overpayments totaling $531,797 that the providers had not refunded by the beginning of our audit.

Of the 418 incorrect line items:

- Providers reported incorrect units of service on 343 line items, resulting in overpayments totaling $435,099.

- Providers did not provide supporting documentation for 26 line items, resulting in overpayments totaling $31,005.

- Providers billed for unallowable services on nine line items, resulting in overpayments totaling $19,257.

- Providers billed separately for services on 18 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling $18,722.

[5] 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 $500.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on nine line items, resulting in overpayments totaling $11,600.

- Providers used incorrect HCPCS codes on 11 line items, resulting in overpayments totaling $10,766.

- One provider billed for the unlabeled use of a drug/biological on one line item, resulting in an overpayment totaling $3,657.

- Highmark incorrectly calculated the payment for one line item that resulted in an overpayment of $1,691.

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. Highmark 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 343 line items, resulting in overpayments totaling $435,099. Primarily, these overpayments occurred for two reasons:

- Fifty providers billed Medicare on 285 line items with incorrect units involving 42 different drugs, biologicals,[6] and blood products. Rather than billing between 1 and 350 service units, providers billed between 3 and 10,000 service units. These errors occurred because of human error or because the provider's chargemaster[7] was incorrect. As a result of these errors, Highmark paid the 50 providers a total of $475,556 when it should have paid $112,763, an overpayment of $362,793.

- Twelve providers billed Medicare for 23 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 23 cases, the provider performed from 1 to 9 surgical procedures but billed for between 3 and 30 services. As a result of these errors, Highmark paid the provider a total of $77,594 when it should have paid $37,049, an overpayment of $40,545.

Unsupported Services

Providers billed Medicare for 26 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 to refund the combined $31,005 in overpayments that they received.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for nine line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling $19,257. For example, four providers billed Medicare for six 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, filing, 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 six dental services billed was an integral part of another covered procedure. As a result of these errors, Highmark incorrectly paid the provider $13,982.

Payment for Packaged Services

Eight providers billed Medicare on 18 line items for services that were not separately payable by Medicare. These services were billed as separately payable drugs rather than ordinary pharmacy drugs that are packaged in the payment for the primary procedure. These errors resulted in overpayments totaling $18,722. For example, 3 providers billed Medicare for 10 line items for the lipid formulation of doxorubicin hydrochloride (HCPCS code J9001) rather than the non-lipid formulation of doxorubicin hydrochloride (HCPCS code J9000), the drug actually administered. During the dates of service that the provider administered this drug, Medicare

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

[7] 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.

included the non-lipid 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, Highmark incorrectly paid the provider $11,365.

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 nine line items. These errors resulted in overpayments totaling $11,600. The following examples illustrate the combination of incorrect number of units of service claimed and incorrect HCPCS codes used:

- One provider billed Medicare for 10 units of HCPCS code J9001 rather than for 8 units of HCPCS code J9000, the drug actually administered. Similar errors occurred on a total of two line items that this provider submitted. As a result of these errors, Highmark paid the provider $6,873 when it should have paid $78, an overpayment of $6,795.

- Another provider billed Medicare for administering six units for an injection of Tacrolimus (HCPCS code J7525); however, the provider should have billed for three units of oral Tacrolimus (HCPCS code J7507). Similar errors occurred on a total of five line items that this provider submitted. As a result, Highmark paid the provider a total of $3,650 when it should have paid $52, an overpayment of $3,598.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used incorrect HCPCS codes for 11 line items, resulting in overpayments totaling $10,766. For example, one provider billed Medicare for nine line items for HCPCS code J9001 rather than HCPCS code J9000, the drug actually administered.[8] As a result, Highmark paid the provider a total of $8,626 when it should have paid $135, an overpayment of $8,491.

Unlabeled Use of a Drug/Biological

One provider billed Medicare for the unlabeled use of the biological Retavase for 1 line item for 6 units, resulting in overpayments totaling $3,657. 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[9] 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

[8] Although Medicare did not pay separately for HCPCS code J9000 administered during calendar years 2006, 2008, and 2009, Medicare did pay for HCPCS code J9000 administered during calendar year 2007.

[9] 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.

> 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.[10] However, the provider submitted this line item as if six single-use doses were administered for the labeled use. Consequently, Highmark did not know that the one line item was for an unlabeled use that required a case-by-case payment determination and incorrectly paid the provider $3,657.

Incorrect Medicare Reimbursement

One provider correctly billed Medicare for one line item for eight units for intermittent peritoneal dialysis treatments using the appropriate revenue code.[11] According to the provider, Highmark told the provider that the Medicare payment system appeared to have paid an incorrect amount. Highmark paid the provider $2,537 when it should have paid $846, an overpayment of $1,691.

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. Highmark 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.[12]

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.

---

[10] Providers should indicate the unlabeled use of a drug or biological in the comments section of the claim. In addition, beginning July 11, 2008, Highmark required providers to use modifier "KX" on each claim line billed for an unlabeled use of a drug or biological to verify that the documentation requirements of Pub. No. 100-02, chapter 15, section 50.4.2 have been met. (See *Approved Drugs and Biologicals; Includes Cancer Chemotherapeutic Agents* (Highmark Billing & Coding Article A47797, July 11, 2008, revised April 13, 2011)).

[11] Revenue codes indicate the general category of service provided and may affect the processing and payment of the claim.

[12] 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 Highmark:

- recover the $531,797 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.

HIGHMARK MEDICARE SERVICES COMMENTS

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

APPENDIX

APPENDIX: HIGHMARK MEDICARE SERVICES COMMENTS

HIGHMARK
MEDICARE SERVICES
ISO 9001:2008 CERTIFIED

July 22, 2010

RE: Report Number A-03-11-00004

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

Dear Mr. Virbitsky,

This letter is in response to your letter dated June 28, 2011, regarding the draft report for audit number A-03-11-00004, *Review of Medicare Payments Exceeding Charges By $500 to $1,000 for Outpatient Services Processed by Highmark Medicare Services in Jurisdiction 12 for the Period January 1, 2006 Through June 30, 2009.*

HMS was the legacy contractor for Pennsylvania and Maryland/District of Columbia (Part A) during the scope of this audit. HMS began processing claims associated with Delaware, the DC metropolitan area, Maryland (Part B) and New Jersey in 2008 as part of the Medicare Administrative Contractor Jurisdiction 12 transition.

Recommendation that Highmark *recover the $531,797 in identified overpayments:*

Response: Highmark Medicare Services (HMS) has been working the overpayments in accordance with the applicable IOM and will coordinate recoveries outside of that guidance with the J12 COTR.

Finding: *Highmark incorrectly calculated the payment for one line item that result in an overpayment of $1,691.*

HMS reviewed the claims associated with the finding. We concur with this statement and will recover the overpayment per established guidelines.

We concur with the OIG's characterization that at the time HMS made the incorrect payments neither the Fiscal Intermediary Standard System not CWF had sufficient editing in place to prevent or detect the overpayment.

Recommendation that Highmark *implement system edits that identify line item payments that exceed billed charges by a prescribed amount:*

Response: HMS is conducting analysis of the issue and will be reviewing corrective actions during our next scheduled MIP meeting. Any identified vulnerabilities will be pursued following the prescribed progressive corrective action process.

Recommendation that Highmark *use the results of this audit in its provider education activities:*

Response: HMS will use the findings listed to develop targeted provider education opportunities.

If there are any other questions or concerns, please do not hesitate to contact me at (717) 302-4410 or Michele Daley-Ryan at (717) 713-0252.

Sincerely,

/E. James Bylotas/
Director, Quality and Performance Management