November 18, 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 Cahaba Government Benefit Administrators, LLC, in Jurisdiction 10 for the Period January 1, 2006, Through December 31, 2007 (A-04-10-06121)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by Cahaba Government Benefit Administrators, LLC (Cahaba), in Jurisdiction 10. We will issue this report to Cahaba 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 Lori S. Pilcher, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through email at Lori.Pilcher@oig.hhs.gov. Please refer to report number A-04-10-06121.

Attachment

Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

November 22, 2011

Report Number: A-04-10-06121

Ms. Molly Echols
Compliance Officer
Cahaba Government Benefit Administrators, LLC
300 Corporate Parkway
Birmingham, AL 35242

Dear Ms. Echols:

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 Cahaba Government Benefit Administrators, LLC, in Jurisdiction 10 for the Period January 1, 2006, Through December 31, 2007*. 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 Andrew Funtal, Audit Manager, at (404) 562-7762 or through email at Andrew.Funtal@oig.hhs.gov. Please refer to report number A-04-10-06121 in all correspondence.

Sincerely,

/Lori S. Pilcher/
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 MEDICARE PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, IN JURISDICTION 10 FOR THE PERIOD JANUARY 1, 2006, THROUGH DECEMBER 31, 2007

Daniel R. Levinson
Inspector General

November 2011
A-04-10-06121

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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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.

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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.

In January 2009, Cahaba Government Benefit Administrators, LLC (Cahaba), was awarded the Medicare administrative contract for Jurisdiction 10 in three States. During our audit period (January 2006 through December 2007), approximately 131.8 million line items for outpatient services were processed in Jurisdiction 10, of which 749 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.")

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 749 selected line items for which Cahaba made Medicare payments to providers for outpatient services during our audit period, 46 were correct. Providers refunded overpayments on 148 line items totaling $892,788 prior to our fieldwork. The remaining 555 line items were

incorrect and included overpayments totaling $2,812,952, which the providers had not refunded by the beginning of our audit.

Of the 555 incorrect line items:

- Providers reported incorrect units of service on 401 line items, resulting in overpayments totaling $2,267,911.

- Providers used HCPCS codes that did not reflect the procedures performed on 92 line items, resulting in overpayments totaling $302,082.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 28 line items, resulting in overpayments totaling $137,794.

- Providers billed for unallowable services on 21 line items, resulting in overpayments totaling $59,619.

- Providers did not provide the supporting documentation for 13 line items, resulting in overpayments totaling $45,546.

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. Cahaba made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to detect and prevent the overpayments.

RECOMMENDATIONS

We recommend that Cahaba:

- recover the $2,812,952 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.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

In written comments on our draft report, Cahaba concurred with our first and third recommendations and described interim actions that it would take to implement our second recommendation. Cahaba said that the second recommendation should be directed to CMS because CMS could issue a Change Request to have the system maintainer hardcode the edits throughout the system, thus ensuring that all contractors have the same edits. Cahaba's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We encourage Cahaba to take the interim steps and 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.

[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.

Cahaba Government Benefit Administrators, LLC

In January 2009, Cahaba Government Benefit Administrators, LLC (Cahaba), was awarded the Medicare administrative contract for Jurisdiction 10 in three States: Alabama, Georgia, and Tennessee.[3] During our audit period (January 2006 through December 2007), approximately 131.8 million line items for outpatient services were processed in Jurisdiction 10.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the 131.8 million line items for outpatient services that Cahaba processed during the period January 2006 through December 2007, 749 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 limited our review of Cahaba'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 Cahaba, located in Birmingham, Alabama, and the 121 providers that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[3] Prior to the award, providers in Alabama, Georgia, and Tennessee submitted Medicare outpatient claims through separate fiscal intermediaries. In January 2009, Cahaba was awarded the MAC contract for these States. In September 2009, Cahaba assumed full responsibility for the MAC workload in Jurisdiction 10 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 by at least $1,000 and (2) the line item had 3 or more units of service;[5]

- identified 749 line items, totaling approximately $4.3 million, that Medicare paid to 124 providers;

- contacted 121 of the 124 providers that received Medicare payments associated with the selected line items[6] 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 Cahaba; and

- discussed the results of our review with Cahaba officials on March 9, 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 749 selected line items for which Cahaba made Medicare payments to providers for outpatient services during our audit period, 46 were correct. Providers refunded overpayments on 148 line items totaling $892,788 prior to our fieldwork. The remaining 555 line items were incorrect and included overpayments totaling $2,812,952 that the providers had not refunded by the beginning of our audit.

Of the 555 incorrect line items:

- Providers reported incorrect units of service on 401 line items, resulting in overpayments totaling $2,267,911.

- Providers used HCPCS codes that did not reflect the procedures performed for 92 line items, resulting in overpayments totaling $302,082.

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

[6] We did not contact 3 of the 124 providers and did not review 135 of the 749 line items because, before we began contacting providers, we determined that these 3 providers refunded overpayments before our fieldwork.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 28 line items, resulting in overpayments totaling $137,794.

- Providers billed for unallowable services on 21 line items, resulting in overpayments totaling $59,619.

- Providers did not provide supporting documentation for 13 line items, resulting in overpayments totaling $45,546.

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. Cahaba 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." [7] 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 401 line items, resulting in overpayments totaling $2,267,911. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for incorrect service units on 34 line items. Rather than billing between 1 and 2 service units (the correct range for the HCPCS codes associated

[7] 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.

with these line items), the provider billed between 10 and 22 service units. These errors occurred because the provider's chargemaster[8] was incorrect. As a result of these errors, Cahaba paid the provider $170,600 when it should have paid $15,312, an overpayment of $155,288.

- Another provider billed Medicare for incorrect service units on 29 line items. Rather than billing between 1 and 10 service units, the provider billed between 54 and 250 service units. These errors occurred because the provider's computer software was programmed incorrectly. As a result of these errors, Cahaba paid the provider $156,742 when it should have paid $2,937, an overpayment of $153,805.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed for 92 line items, resulting in overpayments totaling $302,082. For example, because of human error, a provider billed Medicare for 44 line items with a HCPCS code for a thyroid procedure rather than using the correct HCPCS code for a drug involving a stress test procedure. As a result of this error, Cahaba paid the provider $73,844 when it should have paid $963, an overpayment of $72,881.

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 28 line items. These errors resulted in overpayments totaling $137,794. The following examples illustrate the combination of incorrect units of service claimed and incorrect HCPCS codes used:

- One provider billed Medicare for a procedure with nine units of service. However, the provider should have billed using a different HCPCS code with one unit of service. As a result, Cahaba paid the provider $4,180 when it should have paid $836, an overpayment of $3,344.

- For 2 line items on 1 claim, another provider incorrectly billed Medicare for 20 units of service for a transfusion procedure when it should have billed 1 unit of service. For the same line items, this provider also used an incorrect HCPCS code for a product used during the transfusion procedure. As a result of these errors, Cahaba paid the provider $6,863 when it should have paid $661, an overpayment of $6,202.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for 21 line items for services that were not allowable for Medicare reimbursement, resulting in overpayments totaling $59,619. For example, one provider billed Medicare for one line item that was unrelated to outpatient services. Specifically, the provider billed Medicare outpatient services for dental procedures that are not covered by

[8] A provider's chargemaster contains data on every chargeable item or procedure that the provider offers.

Medicare. For one such procedure, the provider billed for the removal of teeth, which is not a covered procedure according to the *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 150. As a result of this error, Cahaba paid the provider $5,834 when it should have paid $0, an overpayment of $5,834.

Unsupported Services

Nine providers billed Medicare for 13 line items for which the providers did not provide supporting documentation. The providers agreed to cancel the claims associated with these line items and refund the combined $45,546 in overpayments.

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. Cahaba 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 and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that Cahaba:

- recover the $2,812,952 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.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

In written comments on our draft report, Cahaba concurred with our first and third recommendations and described interim actions that it would take to implement our second recommendation. Cahaba said that the second recommendation should be directed to CMS

[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.

because CMS could issue a Change Request to have the system maintainer hardcode the edits throughout the system, thus ensuring that all contractors have the same edits. Cahaba's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We encourage Cahaba to take the interim steps and implement system edits to the extent possible under its current contract with CMS.

APPENDIX

APPENDIX: CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

August 17, 2011

John T. Drake, Sr.
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW
Suite 3T41
Atlanta, GA 30303

RE: Report Number: A-04-10-06121 *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Cahaba Government Benefit Administrators®, LLC, in Jurisdiction 10 for the Period January 1, 2006, Through December 31, 2007*

Dear Mr. Drake:

This report is in response to the draft report issued to Cahaba Government Benefit Administrators®, LLC (Cahaba GBA) for the above mentioned audit.

OIG Recommendations

We recommend that Cahaba use the results of this audit in its provider education activities.

Cahaba's Response: We have developed a letter to be sent to the Part A providers via listserv, and it will be placed in the next available Medicare Newsline under the What's New Section. The Clinical Provider Outreach and Education Consultants will also add this information to their applicable outreach events.

We recommend that Cahaba implement system edits that identify line item payments that exceed billed charges by a prescribed amount.

Cahaba's Response: We agree to work with CMS to strengthen FISS prepayment edits by revising the unit amount thresholds for certain medical devices. OIG should make the recommendation to CMS to issue a Change Request to have the system maintainer hardcode the edits thus ensuring all contractors have the same edits in place including the same group of HCPCS codes.

In the interim, the Medical Director will review the list of devise HCPCS. For those items where only one unit should ever be billed, a local edit can be created to RTP the claims for verification and correction. If there ever should be a need to bill more than one unit on any of the HCPCS, we can have that edit created to develop for records.

We recommend that Cahaba recover the $2,812,952 in identified overpayments.

Cahaba's Response: Upon receipt of the detail identifying the $2,812,952 in overpayments from OIG, Cahaba will begin adjusting and collection efforts on this sample.

If you should have any questions regarding this report, please contact Molly Echols, Compliance Officer at (205) 220-1587 or via email at Mechols@cahabagba.com.

Sincerely,

Molly Echols
Compliance Officer
Cahaba Government Benefit Administrators®, LLC

CC: Sherrie LeMier, President and Chief Operating Officer of Cahaba GBA
Brandon Ward, Vice President, Cahaba GBA Operations
Gail Dugger, Department Manager Operations
Yelonda Jones, Medicare Operations Manager
Dr. Greg McKinney, Sr. Contractor Medical Director