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

Washington, D.C. 20201

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 First Coast Service Options, Inc., in Jurisdiction 9 for the Period January 1, 2008, Through June 30, 2009 (A-04-10-06128)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by First Coast Service Options, Inc. (First Coast), in Jurisdiction 9. We will issue this report to First Coast 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-04-10-06128.

Attachment

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

November 22, 2011

Report Number: A-04-10-06128

Ms. Sandy Coston
President, Chief Executive Officer
First Coast Service Options, Inc.
532 Riverside Avenue, 20 T
Jacksonville, FL 32202

Dear Ms. Coston:

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 First Coast Service Options, Inc., in Jurisdiction 9 for the Period January 1, 2008, Through June 30, 2009.* We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Andrew Funtal, Audit Manager, at (404) 562-7762 or through email at Andrew.Funtal@oig.hhs.gov. Please refer to report number A-04-10-06128 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 FIRST COAST SERVICE OPTIONS, INC., IN JURISDICTION 9 FOR THE PERIOD JANUARY 1, 2008, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

November 2011
A-04-10-06128

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.

In September 2008, First Coast Service Options, Inc. (First Coast), was awarded the Medicare administrative contractor contract for Jurisdiction 9, which includes Florida, Puerto Rico, and the U.S. Virgin Islands. During our audit period (January 2008 through June 2009), approximately 78 million line items for outpatient services were processed in Jurisdiction 9, of which 295 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 First Coast made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 295 selected line items for which First Coast made Medicare payments to providers for outpatient services during our audit period, 179 were correct. Providers refunded overpayments on three line items totaling $544,153 before our fieldwork. The remaining 113 line items were

incorrect and included overpayments totaling $847,321, which the providers had not refunded by the beginning of our audit.

Of the 113 incorrect line items:

- Providers reported incorrect units of service on 71 line items, resulting in overpayments totaling $485,108.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 29 line items, resulting in overpayments totaling $205,716.

- Providers used HCPCS codes that did not reflect the procedures performed on 10 line items, resulting in overpayments totaling $150,819.

- Providers did not provide the supporting documentation for three line items, resulting in overpayments totaling $5,678.

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. First Coast 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 First Coast:

- recover the $847,321 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.

FIRST COAST SERVICE OPTIONS, INC., COMMENTS

In written comments on our draft report, First Coast agreed with our first and third recommendations. In regard to our second recommendation, First Coast said that its claims processing system did not have the capability to identify line item payments that exceed billed charges. First Coast stated that it had implemented several edits to address excessive charges and that many of those edits were revised or implemented after our audit concluded. First Coast also acknowledged that a base system change via a national edit was necessary for implementation and that such a request had been created. First Coast's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We are encouraged that First Coast has embraced the recommendations and described steps that it has taken and that are in process.

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.

First Coast Service Options, Inc.

In September 2008, First Coast Service Options, Inc. (First Coast), was awarded the Medicare contractor administrative contract for Jurisdiction 9, which includes Florida, Puerto Rico, and the U.S. Virgin Islands.[3] During our audit period (January 2008 through June 2009), approximately 78 million line items for outpatient services were processed in Jurisdiction 9.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the approximately 78 million line items for outpatient services that First Coast processed during the period January 2008 through June 2009, 295 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 First Coast'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 First Coast, in Jacksonville, Florida, and the 50 providers in Jurisdiction 9 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[3] Prior to September 2008, providers processed Medicare outpatient claims through separate fiscal intermediaries. In September 2008, First Coast was awarded the MAC contract for Jurisdiction 9, and, in March 2009, First Coast assumed full responsibility for the Medicare Part A and Part B workload in Jurisdiction 9. Therefore, First Coast is responsible for collecting any overpayments and resolving the issues related to this audit.

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

- used CMS's National Claims History file to identify 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 295 line items totaling approximately $2 million that Medicare paid to 50 providers;

- contacted the 50 providers that received Medicare payments for 295 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 First Coast; and

- discussed the results of our review with First Coast on March 4, 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 295 selected line items for which First Coast made Medicare payments to providers for outpatient services during our audit period, 179 were correct. Providers refunded overpayments on three line items totaling $544,153 before our fieldwork. The remaining 113 line items were incorrect and included overpayments totaling $847,321, which the providers had not refunded by the beginning of our audit.

Of the 113 incorrect line items:

- Providers reported incorrect units of service on 71 line items, resulting in overpayments totaling $485,108.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 29 line items, resulting in overpayments totaling $205,716.

[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 review 3 of the 295 line items because providers refunded overpayments before our fieldwork.

- Providers used HCPCS codes that did not reflect the procedures performed on 10 line items, resulting in overpayments totaling $150,819.

- Providers did not provide the supporting documentation for three line items, resulting in overpayments totaling $5,678.

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. First Coast 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 71 line items, resulting in overpayments totaling $485,108. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for incorrect service units on two line items used for intravenous immune globulin treatment. Rather than billing 60 service units for the HCPCS code associated with these line items, the provider billed 1,200 service units. These errors occurred because the provider incorrectly converted the service units for this HCPCS code. As a result of these errors, First Coast paid the provider $79,896 when it should have paid $3,295, an overpayment of $76,601.

- Another provider billed Medicare for incorrect service units on one line item. Rather than billing for 200 service units, the provider billed for 500 service units. According to the provider, the incorrect billing occurred because of a clerical error. As a result of this error, First Coast paid the provider $33,864 when it should have paid $13,081, an overpayment of $20,783.

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 29 line items. These errors resulted in overpayments totaling $205,716. For example, 1 provider incorrectly billed Medicare for a cancer treatment procedure with 440 units of service. However, the treatment was coded incorrectly. The provider should have billed using a different procedure code with 15 units of service. This error occurred on two line items that this provider submitted. As a result, First Coast paid the provider $6,146 when it should have paid $353, an overpayment of $5,793.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 10 line items, resulting in overpayments totaling $150,819. For example, a provider billed Medicare for eight line items of infusion therapy using an incorrect chemotherapy injection code. Because of human error, the provider billed Medicare using a code that did not reflect the services provided. As a result of these errors, First Coast paid the provider $133,694 when it should have paid $383, an overpayment of $133,311.

Unsupported Services

Three providers billed Medicare for three line items for which the providers did not provide supporting documentation. First Coast overpaid these providers $5,678.

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. First Coast 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.[7]

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and

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

requires Medicare contractors to determine the legitimacy of the claims. However, this edit did not detect the errors that we found because the edit considers only the amount of the payment, suspends only those payments that exceed the threshold, and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that First Coast:

- recover the $847,321 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.

FIRST COAST SERVICE OPTIONS, INC., COMMENTS

In written comments on our draft report, First Coast agreed with our first and third recommendations. In regard to our second recommendation, First Coast said that its claims processing system did not have the capability to identify line item payments that exceed billed charges. First Coast stated that it had implemented several edits to address excessive charges and that many of those edits were revised or implemented after our audit concluded. First Coast also acknowledged that a base system change via a national edit was necessary for implementation and that such a request had been created. First Coast's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We are encouraged that First Coast has embraced the recommendations and described steps that it has taken and that are in process.

APPENDIX

APPENDIX: FIRST COAST SERVICE OPTIONS, INC., COMMENTS

Sandy Coston
CEO & President
First Coast Service Options, Inc.
Sandy.Coston@fcso.com

August 3, 2011

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

Reference: A-04-10-06128

Dear Mr. Drake:

We received the U.S. Department of Health & Human Services, Office of Inspector General (OIG) draft report entitled, "Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by First Coast Service Options, Inc. in Jurisdiction 9 for the Period January 1, 2008, Through June 30, 2009" and reviewed the findings and recommendations. We appreciate the opportunity to review and provide comments prior to release of the final report.

In the draft report, you outlined three recommendations that we have addressed as follows:

Recommendation:

Recover the $847,321 in identified overpayments.

Response:

First Coast Service Options, Inc. (FCSO) has initiated its standard overpayment recovery procedures to recover the claims identified by the OIG.

Recommendation:

Implement system edits that identify line item payments that exceed billed charges by a prescribed amount.

Response:

The Fiscal Intermediary Standard System (FISS) does not have the current capability to identify line item payments that exceed the billed charges. The current editing stops the claim at the medical policy parameter phase and at that point in the processing cycle the reimbursement amount has not calculated. FISS is a CMS provided standard system that is used for Part A claims processing. Base system changes in FISS would be required to implement editing that has the ability to stop the claim and compare the charges after medical policy editing and payment.

532 Riverside Avenue, Jacksonville, Florida 32202
P.O. Box 45274, Jacksonville, Florida 32234-5274
Tel: 904-791-8409
Fax: 904-361-0372
www.fcso.com

On the June 27, 2011 Core Workgroup conference call this was an agenda item due to an OIG nationwide audit. A User Change Request J30048 was created requesting a national edit as base system changes are necessary for implementation.

FCSO currently has 11 locally defined threshold edits in place for various bill types to address excessive charges. These edits are driven by the billed charges since we cannot suspend based on reimbursement. Also, FCSO has implemented high dollar threshold edits to prevent some excessive billing/charges. Many of these edits were revised and/or implemented since the review period of this audit.

Recommendation:

Use the results of this audit in its provider education activities

Response:

FCSO will incorporate examples of billing errors found in this report in future education efforts. An analysis of the results will be completed to determine if provider specific education and/or widespread education is more appropriate. Educational efforts will include a particular emphasis on units of service issues that led to claims being reimbursed at excessive payment amounts.

Again, we appreciate the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding our responses, please contact Mr. Gregory W. England at (904) 791-8364.

Sincerely,

/Sandy Coston/