October 17, 2011

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

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

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 15 for the Period January 1, 2006, Through June 30, 2009 (A-05-10-00016)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by National Government Services in Jurisdiction 15. We will issue this report to National Government Services 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 Sheri L. Fulcher, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through email at Sheri.Fulcher@oig.hhs.gov. Please refer to report number A-05-10-00016.

Attachment

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

Office of Audit Services, Region V
233 North Michigan Ave., Suite 1360
Chicago, Illinois 60601

October 20, 2011

Report Number: A-05-10-00016

Ms. Sandra Miller
President
National Government Services
8115 Knue Road
Indianapolis, IN 46250

Dear Ms. Miller:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by National Government Services in Jurisdiction 15 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 contact Tate Clark, Senior Auditor, at (217) 793-5010, extension 105, or through email at Tate.Clark@oig.hhs.gov or Stephen Slamar, Audit Manager, at (312) 353-7905 or through email at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-10-00016 in all correspondence.

Sincerely,

/Sheri L. Fulcher/
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 NATIONAL GOVERNMENT SERVICES IN JURISDICTION 15 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

October 2011
A-05-10-00016

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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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.

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THIS REPORT IS AVAILABLE TO THE PUBLIC

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

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

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

During our audit period (January 1, 2006, through June 30, 2009), National Government Services was the Medicare contractor for Jurisdiction 15 in Ohio and Kentucky. For Jurisdiction 15, National Government Services processed approximately 195 million line items for outpatient services during the audit period, of which 1,290 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 National Government Services made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 1,290 selected line items for which National Government Services made Medicare payments to providers for outpatient services during our audit period, 120 line items were correct. Providers refunded overpayments on 201 line items totaling $742,985 before our fieldwork. The remaining 969 line items were incorrect and included overpayments totaling at least $4,958,011, which the providers had not refunded by the beginning of our audit.

Of the 969 incorrect line items:

- Providers reported incorrect units of service on 560 line items, resulting in overpayments totaling at least $3,338,648.

- Providers used HCPCS codes that did not reflect the procedures performed on 142 line items, resulting in overpayments totaling $854,660.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 261 line items, resulting in overpayments totaling $740,434.

- Providers billed for unallowable services on four line items, resulting in overpayments totaling $18,586.

- Providers did not provide the supporting documentation for two line items, resulting in overpayments totaling $5,683.

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. National Government Services 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 National Government Services:

- recover the $4,958,011 in identified overpayments,

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

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

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, regarding our first recommendation, National Government Services said that it would review each case and work to recover the amounts due to the program upon final determination. Citing limitations within CMS's Part A processing system, National Government Services stated that our second recommendation to implement system edits would "require additional clarification and discussion." Regarding our third recommendation, National Government Services stated that it would continue its ongoing provider education. National Government Services also stated that the transition to the Medicare administrative contractor (MAC) was anticipated to be completed by October 17, 2011, and that, as required by the transition guidelines, it would end its outreach efforts 60 days prior to the

transfer of functions to the MAC. National Government Services' comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. 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 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 (also known as a line item). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.[2] In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

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

National Government Services

National Government Services is the Medicare contractor for Jurisdiction 15, which consists of Ohio and Kentucky.[3] During our audit period (January 1, 2006, through June 30, 2009), National Government Services processed approximately 195 million line items for outpatient services in Jurisdiction 15.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the approximately 195 million line items for outpatient services that National Government Services processed during the period January 2006 through June 2009, 1,290 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 National Government Services' 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 National Government Services, in Louisville, Kentucky, and the 137 providers in Jurisdiction 15 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[3] CIGNA Government Services, LLC (CGS), was awarded the Part A and Part B MAC contract for Jurisdiction 15. The Part A workload for Ohio and Kentucky will be transferred from National Government Services to CGS in October 2011. Until then, National Government Services will continue to serve as the legacy fiscal intermediary for providers in Ohio and Kentucky.

[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 1,290 line items totaling approximately $6.8 million that Medicare paid to 137 providers;

- contacted 135 providers that received Medicare payments for 1,107 line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;[6]

- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;

- coordinated the calculation of overpayments with National Government Services; and

- discussed the results of our review with National Government Services on February 8, 2011.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 1,290 selected line items for which National Government Services made Medicare payments to providers for outpatient services during our audit period, 120 line items were correct. Providers refunded overpayments on 201 line items totaling $742,985 before our fieldwork. The remaining 969 line items were incorrect and included overpayments totaling at least $4,958,011, which the providers had not refunded by the beginning of our audit.

Of the 969 incorrect line items:

- Providers reported incorrect units of service on 560 line items, resulting in overpayments totaling at least $3,338,648.

[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 183 of the 1,290 line items because providers refunded overpayments before our fieldwork and because payments no longer exceeded charges by at least $1,000 for those line items.

- Providers used HCPCS codes that did not reflect the procedures performed on 142 line items, resulting in overpayments totaling $854,660.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 261 line items, resulting in overpayments totaling $740,434.

- Providers billed for unallowable services on four line items, resulting in overpayments totaling $18,586.

- Providers did not provide the supporting documentation on two line items, resulting in overpayments totaling $5,683.

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. National Government Services 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 560 line items, resulting in overpayments totaling $3,338,648. The following examples illustrate the incorrect units of service:

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

- One provider billed Medicare for incorrect service units on nine line items. Rather than billing 38 service units for the HCPCS code associated with these line items, the provider billed 380 service units. These errors occurred because the provider's chargemaster[8] was incorrect. As a result of these errors, National Government Services paid the provider $176,896 when it should have paid $14,840, an overpayment of $162,056.

- Another provider billed Medicare for incorrect service units on 27 line items. Rather than billing for 1 service unit, the provider billed for 75 service units. These errors occurred because of an error in the provider's computer software. As a result of these errors, National Government Services paid the provider $97,259 when it should have paid $1,296, an overpayment of $95,963.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 142 line items, resulting in overpayments totaling $854,660. For example, because of human error, a provider billed Medicare for 101 line items with an HCPCS code for an injection used to treat various types of cancer in patients instead of the correct HCPCS code for an injection used to increase red blood cell production and treat anemia. As a result of these errors, National Government Services paid the provider $698,624 when it should have paid $13,731, an overpayment of $684,893.

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 261 line items. These errors resulted in overpayments totaling $740,434. For example, 1 provider billed Medicare for 1,248 units using HCPCS code J1950 instead of properly billing 624 units using the correct HCPCS code J9217. As a result of these errors, National Government Services paid the provider $441,431 when it should have paid $117,196, an overpayment of $324,235.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for four line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling $18,586. For example, one provider billed Medicare for two line items that were unrelated to outpatient services. The provider incorrectly billed Medicare outpatient services for dental procedures that are not covered by Medicare. For one such procedure, the provider billed for the extraction of a tooth, 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 these errors, National Government Services paid the provider $8,167 when it should have paid $0, an overpayment of $8,167.

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

Unsupported Services

One provider billed Medicare for two line items for which the provider could not provide supporting documentation. The provider agreed to cancel the claim associated with the line items and refund the $5,683 overpayment that it received.

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. National Government Services 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 all 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 National Government Services:

- recover the $4,958,011 in identified overpayments,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, regarding our first recommendation, National Government Services said that it would review each case and work to recover the amounts due to the program upon final determination. Citing limitations within CMS's Part A processing system, National Government Services stated that our second recommendation to implement system edits would "require additional clarification and discussion." Regarding our third recommendation, National Government Services stated that it would continue its ongoing

[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.

provider education. National Government Services also stated that the transition to the MAC was anticipated to be completed by October 17, 2011, and that, as required by the transition guidelines, it would end its outreach efforts 60 days prior to the transfer of functions to the MAC. National Government Services' comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

APPENDIX

National Government Services

Medicare

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

August 10, 2011

Mr. James M. Barton
Acting Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue, Suite 1360
Chicago, IL 60601

Report Number: A-05-10-00016

Dear Mr. Barton,

The following presents our response to the comments made in your report dated July 11, 2011:

Recommendation 1 - Recover the $4,958,011 in identified overpayments
Based on the findings provided of the claim detail, NGS will review each case and work accordingly to recover the amounts due to the program upon final determination.

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

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

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

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

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

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

Provider Outreach and Education (POE) will research the issues identified within the report and the reasons stated by the Ohio and Kentucky providers as reasons for the incorrect overpayments. POE will provide ongoing education via the National Government Services web site and listserv notices to the Ohio and Kentucky providers regarding outpatient claim errors until August 2011. The transition to a MAC Jurisdiction for Ohio and Kentucky providers is anticipated to be completed by October 17, 2011; however,

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

National Government Services will end its outreach efforts 6o-days prior to this transition (per the guidelines required for this activity). Until the time of the transition, POE will monitor data for trends, utilization patterns, denials and provide web articles and list serves where high denials have been identified for outpatient services. POE will continue to send edit effectiveness web articles and list serve messages when edits are put in the system based on LCD edit rollouts that will affect these providers until October 2011. POE will continue to do mass mailings to those providers who are identified through data that could be impacted by LCD edits implemented in the system.

Sincerely yours,

/Sharon Weddel/

Sharon Weddel,
Director NGS Operations