December 13, 2011

TO: Marilyn Tavenner
Acting 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, Inc., in Jurisdiction 6 – Illinois and Wisconsin for the Period January 1, 2006, Through June 30, 2009 (A-05-10-00025)

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, Inc. (NGS), in Jurisdiction 6. We will issue this report to NGS 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) 353-1823 or through email at Sheri.Fulcher@oig.hhs.gov. Please refer to report number A-05-10-00025.

Attachment

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

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

December 15, 2011

Report Number: A-05-10-00025

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, Inc., in Jurisdiction 6 – Illinois and Wisconsin 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 Alexandria Hayden, Senior Auditor, at (312) 353-3033, or through email at Alexandria.Hayden@oig.hhs.gov or David Markulin, Audit Manager, at (312) 353-1644 or through email at David.Markulin@oig.hhs.gov. Please refer to report number A-05-10-00025 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, INC., IN JURISDICTION 6 – ILLINOIS AND WISCONSIN FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

December 2011
A-05-10-00025

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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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, Inc. (NGS), was the fiscal intermediary for Jurisdiction 6 in two States, Illinois and Wisconsin. On January 7, 2009, CMS awarded Noridian Administrative Services, LLC, the Medicare Administrative Contractor contract for Jurisdiction 6, which includes Illinois and Wisconsin; however, protests were filed against the award. CMS is taking corrective action on the award. In the meantime, NGS, acting as the legacy fiscal intermediary, continues to process claims for providers in Illinois and Wisconsin. During our audit period, approximately 167.5 million line items for outpatient services were processed for Illinois and Wisconsin, of which 1,547 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 NGS made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 1,547 selected line items for which NGS made Medicare payments to providers for outpatient services during our audit period, 524 were correct. Providers refunded overpayments on 96 line items totaling $1.7 million before our fieldwork. The remaining 927 line items were incorrect. Of these 927 items, 901 included overpayments totaling $6,284,843, which the providers had not refunded by the beginning of our audit. As of February 1, 2011, the amount of overpayment for the 26 remaining items had not been determined because the items had not been reprocessed and the correct line payment amounts identified.

Of the 927 incorrect line items:

- Providers reported incorrect units of service on 699 line items, resulting in identified overpayments totaling at least $5,119,064 (the amount of overpayment for 25 of the 699 line items has not been determined).

- Providers used HCPCS codes that did not reflect the procedures performed on 113 line items, resulting in overpayments totaling $528,317.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 64 line items, resulting in overpayments totaling $460,863.

- Providers billed for unallowable services on 41 line items, resulting in identified overpayments totaling $141,628.

- Providers did not provide the supporting documentation for 10 line items, resulting in overpayments totaling $34,971 (the amount of overpayment for 1 line item has not been determined).

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that NGS:

- recover $6,284,843 in identified overpayments,

- determine the amount of overpayment for the 26 incorrect line item payments and recover that amount,

- 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, NGS agreed with our first recommendation and stated that it had reviewed all of the claims detailed in our audit and the required actions had been completed. Regarding the second recommendation, NGS stated that once the claim adjustment finalizes, it will initiate all 26 claim adjustments and begin the recovery process. Citing limitations within CMS's Part A processing system, NGS stated that our third recommendation to implement system edits would "require additional clarification and discussion." Finally, regarding our fourth recommendation for provider education activities, NGS stated that it would provide ongoing education through its Web site, notices to Illinois and Wisconsin providers, and face-to-face sessions and webinars regarding outpatient claim errors.

NGS's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We encourage NGS 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. 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.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted for outpatient services.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process providers' outpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.[2] In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

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

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

National Government Services, Inc.

During our audit period (January 1, 2006, through June 30, 2009), National Government Services, Inc. (NGS), was the fiscal intermediary for two States within Jurisdiction 6, Illinois and Wisconsin. On January 7, 2009, CMS announced that it had awarded Noridian Administrative Services, LLC, the MAC contract for Jurisdiction 6, which includes Illinois, Minnesota, and Wisconsin; however, protests were filed against the award. While CMS was taking corrective action on the award, NGS, acting as the legacy fiscal intermediary, continued to process claims for providers in Illinois and Wisconsin.[3] NGS processed approximately 167.5 million line items for outpatient services for Illinois and Wisconsin providers during our audit period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the approximately 167.5 million line items for outpatient services that NGS processed during the period January 2006 through June 2009, we reviewed 1,547 line items that 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 NGS's internal controls to those that were applicable to the selected payments because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

Our fieldwork included contacting NGS in Louisville, Kentucky, and the 142[5] providers in Illinois and Wisconsin that received the selected Medicare payments.

[3] CMS reopened the competition for Jurisdiction 6 during the summer of 2010. In September 2011, CMS announced that it had awarded NGS the MAC contract for Jurisdiction 6.

[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."

[5] Five providers refunded overpayments on five selected line items before our fieldwork; therefore, we did not contact those providers.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items in which (1) Medicare line payment amounts exceeded the line billed charge amounts by at least $1,000 and (2) the line item had 3 or more units of service;[6]
- identified 1,547 line items totaling approximately $11.6 million that Medicare paid to 142 providers;
- contacted 137 providers that received Medicare payments for 1,547 line items[7] to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with NGS; and
- discussed the results of our review with NGS on February 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 1,547 selected line items for which NGS made Medicare payments to providers for outpatient services during our audit period, 524 were correct. Providers refunded overpayments on 96 line items totaling approximately $1.7 million before our fieldwork. The remaining 927 line items were incorrect. Of the 927 items, 901 included overpayments totaling at least $6,284,843, which the providers had not refunded by the beginning of our audit. As of

[6] 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.

[7] We did not review 96 of the 1,547 selected line items because providers refunded overpayments before our fieldwork. The 96 includes the 5 line items referred to in footnote 5.

February 1, 2011, the amount of overpayment for the 26 remaining items had not been determined because the items had not been reprocessed and the correct line payment amounts identified.

Of the 927 incorrect line items:

- Providers reported incorrect units of service on 699 line items, resulting in identified overpayments totaling $5,119,064 (the amount of overpayment for 25 of the 699 line items has not been determined).

- Providers used HCPCS codes that did not reflect the procedures performed on 113 line items, resulting in overpayments totaling $528,317.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 64 line items, resulting in overpayments totaling $460,863.

- Providers billed for unallowable services on 41 line items, resulting in identified overpayments totaling $141,628.

- Providers did not provide the supporting documentation for 10 line items, resulting in overpayments totaling $34,971 (the amount of overpayment for 1 line item has not been determined).

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

FEDERAL REQUIREMENTS

Section 1833(e) of the Social Security Act states: "No payment shall be made to any provider of services … unless there has been furnished such information as may be necessary in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …."

CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: "providers must use HCPCS codes … for most outpatient services." Chapter 25, section 75.5, of the Manual states: "when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed." [8] 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

[8] 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.

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 699 line items, resulting in overpayments totaling at least $5,119,064. The amount of overpayment for 25 line items has not been determined because NGS has not reprocessed the line items to determine the correct line payment amounts. The following example illustrates the incorrect units of service. One provider billed Medicare for incorrect service units on 175 line items. Rather than billing for the correct service units chargeable for the HCPCS codes associated with these line items, the provider billed between 1,500 and 75,000 service units. These errors occurred because the provider's internal pharmacy module used an incorrect multiplier. As a result of these errors, NGS paid the provider $1,941,249 when it should have paid $10,229, an overpayment of $1,931,020.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 113 line items, resulting in overpayments totaling $528,317. For example, because of human error, a provider billed Medicare for two line items with an incorrect HCPCS code. In each of these cases, brachytherapy seeds[9] were charged using procedure code 79200 instead of the appropriate code of C1718. As a result, NGS paid the provider $37,101 when it should have paid $6,122, an overpayment of $30,979.

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 64 line items, resulting in overpayments totaling $460,863. For example, one provider billed Medicare for three units of surgical procedure code 26765 rather than one unit of surgical procedure code 26755. The overpayment occurred because of a clerical error on both the number of units and the surgical procedure code. As a result, NGS paid the provider $2,660 when it should have paid $93, an overpayment of $2,567.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for 41 line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling at least $141,628. For example, 1 provider billed Medicare for 14 line items that were unrelated to outpatient services.

[9] Brachytherapy seeds are radioactive material used to treat several types of cancer. The seeds are placed into the area of the tumor and emit radiation until they are no longer active.

Specifically, 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 surgical removal of an erupted 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, NGS paid the provider $58,338 when it should have paid $0, an overpayment of $58,338.

Unsupported Services

Five providers billed Medicare for 10 line items for which they did not provide supporting documentation, resulting in overpayments totaling $42,260. Four providers agreed to cancel the claims associated with these line items and issue a total refund of $34,971. The remaining provider did not respond to our request regarding a line item totaling $7,289. The amount of overpayment for the line item has not been determined because NGS has not reprocessed the line item to determine the correct line payment amount.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.[10]

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.

RECOMMENDATIONS

We recommend that NGS:

- recover $6,284,843 in identified overpayments,
- determine the amount of overpayment for the 26 incorrect line item payments and recover that amount,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and

[10] 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.

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

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, NGS agreed with our first recommendation and stated that it had reviewed all of the claims detailed in our audit and the required actions had been completed. Regarding the second recommendation, NGS stated that once the claim adjustment finalizes, it will initiate all 26 claim adjustments and begin the recovery process. Citing limitations within CMS's Part A processing system, NGS stated that our third recommendation to implement system edits would "require additional clarification and discussion." Finally, regarding our fourth recommendation for provider education activities, NGS stated that it would provide ongoing education through its Web site, notices to Illinois and Wisconsin providers, and face-to-face sessions and webinars regarding outpatient claim errors.

NGS's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

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

APPENDIX

APPENDIX: NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

National Government Services

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

Medicare

November 4, 2011

Mr. Stephen F. Slamar
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

REVISED

Report Number: A-05-10-00025

Dear Mr. Slamar,

The following presents our response to the comments made in your report dated July 6, 2011:

Recommendation 1 - Recover the $6,284,843 in identified overpayments
A review was performed on all outpatient claims detailed in the audit. The required actions have been completed.

Recommendation 2 - Determine the amount of overpayment for the 26 incorrect line item payments and recover that amount
All 26 claim adjustments will be initiated and the recovery process will begin when the claim adjustment finalizes.

Recommendation 3 - 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.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Recommendation 4 - 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 Illinois and Wisconsin providers as reasons for the incorrect overpayments. POE will provide ongoing education via the National Government Services Web site and listserv notices to the Illinois and Wisconsin providers regarding outpatient claim errors. POE will monitor data for trends, utilization patterns, denials and provide web articles and list serves where high denials have been identified. POE will conduct face to face sessions and webinars providing education to the Illinois and Wisconsin providers regarding outpatient services, dates are yet to be determined. The education directed to the Illinois and Wisconsin providers will address data entry errors which result in overpayments as well as underpayments, along with clinical documentation issues.

Sincerely yours,

/s/ Sharon Weddel

Sharon Weddel,
Director NGS Operations