October 26, 2010

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

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation for Calendar Years 2004 Through 2007 (A-07-10-04167)

Attached, for your information, is an advance copy of our final report on payments exceeding charges for outpatient services processed by Wisconsin Physicians Service Insurance Corporation (WPS) for calendar years 2004 through 2007. We will issue this report to WPS 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 Robert A. Vito, Acting Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Robert.Vito@oig.hhs.gov or Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-10-04167.

Attachment

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

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

October 28, 2010

Report Number: A-07-10-04167

Ms. Jared Adair
Senior Vice President
Medicare Operations, Medicare Division
Wisconsin Physicians Service Insurance Corporation
1717 West Broadway
Madison, WI 53713

Dear Ms. Adair:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation for Calendar Years 2004 Through 2007*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling.@oig.hhs.gov. Please refer to report number A-07-10-04167 in all correspondence.

Sincerely,

/Patrick J. Cogley/
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 & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION FOR CALENDAR YEARS 2004 THROUGH 2007

Daniel R. Levinson
Inspector General

October 2010
A-07-10-04167

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 & 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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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 by hospital outpatient departments. 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 hospitals to submit accurate claims for hospital outpatient services. Hospitals 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. In addition, hospitals are required to charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses the hospital outpatient prospective payment system to pay hospitals. In this method of reimbursement, the Medicare payment is not based on the amount that the hospital charges. Consequently, the billed charges (the prices that a hospital sets for its services) do not affect the current Medicare payment amounts. Billed charges generally exceed the amount that Medicare pays the hospital. Therefore, a Medicare payment that significantly exceeds the billed charges is at high risk of overpayment.

During our audit period (calendar years (CY) 2004 through 2007), Wisconsin Physicians Service Insurance Corporation (WPS) was a Medicare contractor in 22 States. WPS processed approximately 59 million outpatient claims during our audit period, 6,034 of which resulted in payments that (1) exceeded charges by at least $500 and (2) were less than $50,000. From the hospitals that submitted these 6,034 claims, we identified all hospitals that had at least 1 claim for which the payment exceeded charges by at least $10,000, and we reviewed all claims for those hospitals. As a result, we reviewed 3,409 payments.

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 3,409 selected Medicare payments that exceeded charges that WPS made for outpatient services for CYs 2004 through 2007, 1,996 were correct. The 1,413 remaining payments were incorrect and included overpayments totaling $9,164,416, which the hospitals had not refunded by the beginning of our audit.

Of the 1,413 incorrect Medicare payments:

- Hospitals reported excessive units of service on 611 claims, resulting in overpayments totaling $6,514,439.

- Hospitals used HCPCS codes that did not reflect the procedures performed for 578 claims, resulting in overpayments totaling $1,898,976.

- Hospitals reported a combination of incorrect units of service claimed and incorrect HCPCS codes for 191 claims, resulting in overpayments totaling $687,765.

- Hospitals billed for unallowable services on 32 claims, resulting in overpayments totaling $62,517.

- A hospital could not provide the supporting documentation for one claim, resulting in an overpayment of $719.

The hospitals 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. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments.

RECOMMENDATIONS

We recommend that WPS:

- recover the $9,164,416 in identified overpayments and

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

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS

In written comments on our draft report, WPS described actions that it had taken or planned to take to address our recommendations. WPS noted that it had adjusted the claims that we identified as overpayments and had recovered $10,675,163 (including $4,920 in interest). WPS's comments are included in their entirety as the Appendix.

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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 by hospital outpatient departments.[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 hospitals' 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 hospitals to submit accurate claims for hospital outpatient services. Hospitals 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.[2] In addition, hospitals are required to charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses the hospital outpatient prospective payment system to pay hospitals. In this method of reimbursement, the Medicare payment is not based on the amount that the hospital charges. Consequently, the billed charges (the prices that a hospital sets for its services) do not affect the current Medicare payment amounts. Billed charges generally exceed the amount that Medicare pays the hospital. Therefore, a Medicare payment that significantly exceeds the billed charges is at high risk of overpayment.

Wisconsin Physicians Service Insurance Corporation

During our audit period (calendar years (CY) 2004 through 2007), Wisconsin Physicians Service Insurance Corporation (WPS) was a Medicare contractor in 22 States: Alabama, Alaska, Arkansas, Florida, Georgia, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky,

[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. For purposes of 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.

Missouri, Nebraska, New Hampshire, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Virginia, Washington, and West Virginia.[3]

WPS processed approximately 59 million outpatient claims during our audit period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the 59 million outpatient claims that WPS processed during CYs 2004 through 2007, 6,034 claims resulted in payments that (1) exceeded charges by at least $500 and (2) were less than $50,000. From the hospitals that submitted these 6,034 claims, we identified all hospitals that had at least 1 claim for which the payment exceeded charges by at least $10,000, and we reviewed all claims for those hospitals. As a result, we reviewed 3,409 payments.[4]

We limited our review of WPS's and the hospitals' internal controls to those that were applicable to the 3,409 selected Medicare 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 WPS, located in Madison, Wisconsin, and Omaha, Nebraska, and contacting the 127 hospitals that received the selected Medicare payments.

Methodology

To accomplish our objective, we did the following:

- We reviewed applicable Federal laws, regulations, and guidance.

- We used CMS's National Claims History file to identify outpatient claims for which the total payment was greater than the total charge by at least $10,000 but not more

[3] Prior to our audit period, hospitals processed Medicare outpatient claims through separate fiscal intermediaries. WPS was the Medicare contractor for these hospitals during our audit period, and WPS is ultimately responsible for collecting the overpayments and resolving any issues as a result of this audit.

[4] We excluded Medicare payments to two hospitals (Swedish Medical Centers) that we reviewed in other audits (A-09-09-00102 and A-09-09-00103).

than $50,000.[5] Further, for the hospitals with at least one claim meeting the above criteria, we reviewed all Medicare outpatient claims for which the total payment exceeded the total charge by at least $500.

- We contacted the 127 hospitals that received the selected Medicare payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect.

- We obtained documentation from the hospitals confirming all incorrect claims identified.

- We coordinated the calculation of overpayments and discussed the results of our review with WPS.

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 3,409 selected Medicare payments that exceeded charges that WPS made for outpatient services for CYs 2004 through 2007, 1,996 were correct. The 1,413 remaining payments were incorrect and included overpayments totaling $9,164,416, which the hospitals had not refunded by the beginning of our audit.

Of the 1,413 incorrect Medicare payments:

- Hospitals reported excessive units of service on 611 claims, resulting in overpayments totaling $6,514,439.

- Hospitals used HCPCS codes that did not reflect the procedures performed for 578 claims, resulting in overpayments totaling $1,898,976.

- Hospitals reported a combination of incorrect units of service claimed and incorrect HCPCS codes for 191 claims, resulting in overpayments totaling $687,765.

- Hospitals billed for unallowable services on 32 claims, resulting in overpayments totaling $62,517.

- A hospital could not provide the supporting documentation for one claim, resulting in an overpayment of $719.

[5] We reviewed some payments of $50,000 and greater in a separate audit (A-01-05-00514) and plan to review additional payments of $50,000 or greater in future audits.

The hospitals 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. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, mandated that the Medicare contractors require hospitals to report claims for hospital outpatient services using the HCPCS. Section 1833(e) of the Social Security Act states: "[n]o 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, chapter 4, section 20.4, states: "The definition of service units … is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of this manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

INCORRECT MEDICARE PAYMENTS

Incorrect Number of Units of Service

Hospitals reported excessive units of service on 611 claims, resulting in overpayments totaling $6,514,439. The following examples illustrate the excessive units of service:

- One hospital billed 48 claims with incorrect service units. Rather than billing between 236 and 380 service units (the correct range for these claims), the hospital billed between 2,360 and 3,800 service units. These errors occurred because the hospital's chargemaster[6] was incorrect. As a result of these errors, WPS paid the hospital $1,317,544 when it should have paid $176,457, an overpayment of $1,141,087.

- Another hospital billed 26 claims with incorrect service units. Rather than billing for 1 service unit, the hospital billed between 11 and 18 service units. These errors occurred because the hospital's computer software was programmed incorrectly. As a result of these errors, WPS paid the hospital $131,252 when it should have paid $19,580, an overpayment of $111,672.

Incorrect Healthcare Common Procedure Coding System Codes

Hospitals used HCPCS codes that did not reflect the procedures performed on 578 claims, resulting in overpayments totaling $1,898,976. For example, because of human error, a hospital billed two claims with an HCPCS code for a spinal cord procedure involving a skin incision rather than using the correct HCPCS code involving a needle puncture of the skin, the procedure actually performed. As a result of these errors, WPS paid the hospital $40,156 when it should have paid $8,543, an overpayment of $31,613.

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

Combination of Incorrect Units of Service and Incorrect Healthcare Common Procedure Coding System Codes

Hospitals reported both excessive units of service and incorrect HCPCS codes on 191 claims. These errors resulted in overpayments totaling $687,765. The following examples illustrate the combination of incorrect units of service claimed and incorrect HCPCS codes used:

- One hospital billed for a procedure with 288 units of service. However, both the procedure billed and the units of service were incorrect. The hospital should have billed using a different procedure code with nine units of service. This type of error occurred on a total of six claims that this hospital submitted. As a result, WPS paid the hospital $100,035 when it should have paid $16,246, an overpayment of $83,789.

- Another hospital incorrectly billed five units of service for an infusion procedure when it should have billed one unit of service. For the same claim, the hospital also used an incorrect HCPCS code for a chemo infusion procedure. As a result of these errors, WPS paid the hospital $14,872 when it should have paid $2,109, an overpayment of $12,763.

Services Not Allowable for Medicare Reimbursement

Hospitals incorrectly billed Medicare for 32 claims for which the services rendered were not allowable for Medicare reimbursement, resulting in overpayments totaling $62,517. The following examples illustrate the unallowable services:

- One hospital posted a filed claim to the wrong patient account because of a clerical error, so the hospital was paid twice for the same service. As a result of this error, WPS paid the hospital $19,604 for the incorrect patient when it should have paid $0, an overpayment of $19,604.

- Another hospital billed Medicare for 22 procedures that were unrelated to outpatient services. Specifically, the hospital billed Medicare outpatient services for dental procedures that are not covered by Medicare. For example, the hospital billed for the repair of a tooth socket, 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, WPS paid the hospital $27,329 when it should have paid $0, an overpayment of $27,329.

Unsupported Claims

One hospital billed Medicare for one claim for which the hospital could not provide supporting documentation. The hospital agreed to cancel the claim and refund the $719 overpayment that it received.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The hospitals 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. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments. In effect, CMS relied on hospitals to notify the Medicare contractors of excessive 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 excessive Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires contractors to determine the legitimacy of the claims. However, this edit did not detect the errors that we found because the edit considers only the amount of the payment and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that WPS:

- recover the $9,164,416 in identified overpayments and

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

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS

In written comments on our draft report, WPS described actions that it had taken or planned to take to address our recommendations. WPS noted that it had adjusted the claims that we identified as overpayments and had recovered $10,675,163 (including $4,920 in interest). WPS's comments are included in their entirety as the Appendix.

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

APPENDIX

APPENDIX: WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS

CMS CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

September 14, 2010

Mr. Patrick J. Cogley
Regional Inspector General Audit Services
Office of Audit Services, Region VII
601 East 12th Street
Kansas City, MO 64106

RE: Office of Inspector General (OIG) Draft Report -- A-07-10-04167

Dear Mr. Cogley,

This letter is in response to the OIG draft report titled *Review of Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation for Calendar Years 2004 Through 2007.*

OIG selected for review 3,409 Medicare payments by WPS that exceeded charges on outpatient services for calendar years 2004 through 2007, of which 1,996 were correct. The 1,413 remaining payments were incorrect with overpayments totaling $9,164,416, which the hospitals had not refunded by the beginning of the audit.

As noted in the OIG report *hospitals attributed the incorrect payment to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units or services and other types of billing errors. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments.*

OIG Recommendations to WPS:

- *recover the $9,164,416 in identified overpayments and*
- *use the results of this audit in its hospital education activities*

WPS's Response to the OIG Recommendations:

- WPS has adjusted the OIG identified claims and recovered $10,675,162.52 (including $4,919.56 in interest) relating to the identified overpayments. The OIG identified overpayment and the actual recovered amount differ due to various reasons, such as missing providers, underpayment claim handling and the actual overpayment amounts.
- Currently, WPS's Part A Provider Outreach & Education staff educates hospital providers on the correct reporting of ICD-9-CM diagnosis/procedure codes and CPT/HCPCS codes. We communicate the critical billing elements that must be reported correctly in order for the claim to process and pay accurately. In addition, we educate on the correct reporting of units for drugs and hours of observation. We stress the importance of using the HCPCS long descriptor to get the correct dosage in order to correctly calculate the units, and we provide examples on how to calculate units when billing drugs and hours of observation. As an additional note, we advise the provider that reporting units accurately ensures correct payment, and incorrect reporting of units may result in significant underpayments or overpayments. In the future, WPS's Part A Provider Outreach & Education staff will include specific education on the items noted in the OIG report when conducting applicable educational events - such as Outpatient Hospital seminars. An educational module containing the specific items found by the OIG is currently in development and will be utilized upon completion with applicable events.

If you have any questions or need additional information, please contact Mark DeFoil at 402-351-6915.

Sincerely,

Janet Kyle

Janet Kyle
Vice President Program Management

cc: John Phelps, CMS
Lisa Goschen, CMS
Debra Keasling, OIG
Carmen Cook, OIG