



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

February 01, 2008

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Report Number: A-02-07-01042

Ms. Joli Juodaitis
Managing Director,
HealthNow New York, Inc.
Upstate Medicare Division
33 Lewis Road
Binghamton, New York 13905

Dear Ms. Juodaitis:

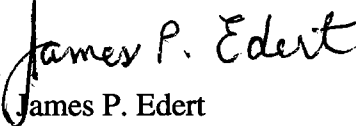
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Medicare Part B Claims Processed by HealthNow New York, Inc., for the Period January 1, 2003, Through December 31, 2005." We will forward a 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please contact Brenda Ryan, Audit Manager, at (212) 246-4677 or through e-mail at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-07-01042 in all correspondence.

Sincerely,


James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Tom Lenz, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

REVIEW OF HIGH-DOLLAR
PAYMENTS FOR MEDICARE
PART B CLAIMS PROCESSED BY
HEALTHNOW NEW YORK, INC.,
FOR THE PERIOD
JANUARY 1, 2003, THROUGH
DECEMBER 31, 2005



Daniel R. Levinson
Inspector General

February 2008
A-02-07-01042

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 all 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. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, 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 in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS 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 age 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 carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers). CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed.

Carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File to process Part B claims. These systems can detect certain improper payments during prepayment validation.

HealthNow New York, Inc., (HealthNow) is the Medicare Part B carrier for about 20,000 providers in 45 upstate New York counties. During calendar years (CY) 2003–2005, HealthNow processed approximately 47 million Part B claims, 268 of which resulted in payments of \$10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether HealthNow's high-dollar Medicare payments to Part B providers were appropriate.

SUMMARY OF FINDING

Of the 268 high-dollar payments that HealthNow made to providers, 249 were appropriate. However, HealthNow overpaid providers \$236,977 for the remaining 19 payments. Providers refunded eight of the overpayments, totaling \$111,575, prior to our fieldwork. Eleven overpayments, totaling \$125,402, remained outstanding.

HealthNow made the overpayments because the providers incorrectly claimed excessive units of service and included charges for services not performed. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–2005 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that HealthNow:

- recover the \$125,402 overpayment,
- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005, and

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

HEALTHNOW NEW YORK, INC.'S COMMENTS

In its January 15, 2008, comments on the draft report, HealthNow agreed with our recommendations. HealthNow's comments are included as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Part B Carriers	1
HealthNow New York, Inc.	1
“Medically Unlikely” Edits.....	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	2
FINDING AND RECOMMENDATIONS	3
MEDICARE REQUIREMENTS	3
INAPPROPRIATE HIGH-DOLLAR PAYMENTS	3
RECOMMENDATIONS	4
HEALTHNOW NEW YORK, INC.’S COMMENTS	4
APPENDIX	
HEALTHNOW NEW YORK, INC.’S COMMENTS	

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B Carriers

Prior to October 1, 2005, section 1842(a) of the Act authorized CMS to contract with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers).¹ Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process providers' claims, carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. During calendar years (CY) 2003–2005, providers nationwide submitted over 2.3 billion claims to carriers. Of these, 29,022 claims resulted in payments of \$10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

HealthNow New York, Inc.

HealthNow New York, Inc., (HealthNow) is the Medicare Part B carrier for about 20,000 providers in 45 upstate New York counties. HealthNow has been processing claims using the Medicare Multi-Carrier System since 1989. During CYs 2003–2005, HealthNow processed approximately 47 million Part B claims, 268 of which resulted in high-dollar payments.

“Medically Unlikely” Edits

In January 2007, after our audit period, CMS required carriers to implement units-of-service edits referred to as “medically unlikely edits.” These edits are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the “Medicare Program Integrity Manual,” Publication 100-08, Transmittal 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, Healthcare Common Procedure Coding System code, date of service, and billing provider against a specified number of units of service. Carriers must deny the entire claim line when the units of service billed exceed the specified number.

¹The Medicare Modernization Act of 2003, Pub. L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace carriers and fiscal intermediaries by October 2011.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether HealthNow's high-dollar Medicare payments to Part B providers were appropriate.

Scope

We reviewed the 268 high-dollar payments, totaling \$3,940,883, that HealthNow processed during CYs 2003–2005.

We limited our review of HealthNow's internal controls to those applicable to the 268 claims 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.

We performed our fieldwork at HealthNow in Binghamton, New York, from April to June 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify Medicare Part B claims with high-dollar payments;
- reviewed available Common Working File claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and
- coordinated our claim review, including the calculation of any overpayments, with HealthNow.

We conducted our review in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

Of the 268 high-dollar payments that HealthNow made to providers, 249 were appropriate. However, HealthNow overpaid providers \$236,977 for the remaining 19 payments. Providers refunded eight of the overpayments, totaling \$111,575, prior to our fieldwork. Eleven overpayments totaling \$125,402 remained outstanding.

HealthNow made the overpayments because the providers incorrectly claimed excessive units of service and included charges for services not performed. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–2005 to detect and prevent payments for these types of erroneous claims.

MEDICARE REQUIREMENTS

The CMS “Carriers Manual,” Publication 14, Part 2, section 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and instructions. Section 5261.3 of the manual requires carriers to effectively and continually analyze “data that identifies aberrancies, emerging trends and areas of potential abuse, overutilization or inappropriate care, and . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes.”

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

For the 19 overpayments, totaling \$236,977, providers incorrectly billed HealthNow for excessive units of service or services not performed. Specifically, for 18 claims, providers incorrectly billed HealthNow for excessive units of service. As a result, HealthNow overpaid providers \$230,832. The following examples illustrate inappropriate units-of-service payments:

- One provider billed 56 units of service (doses of a chemotherapy drug) for 6 units delivered. The provider stated that it had miscalculated the dosage administered. As a result, HealthNow paid the provider \$20,866 when it should have paid \$2,629, an overpayment of \$18,237. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.
- One provider billed 173 units of service (pathology and examination) for 1 unit delivered. The provider stated that it had mistakenly entered the diagnosis code in the units-of-service field. As a result, HealthNow paid the provider \$13,515 when it should have paid \$78, an overpayment of \$13,437. The provider identified and refunded the overpayment prior to our fieldwork.

In addition, for one claim, the provider billed three duplicate charges and one charge for a service not performed. As a result, HealthNow paid the provider \$12,334 when it should have paid \$6,189, an overpayment of \$6,145. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

Providers attributed the incorrect claims to clerical errors made by their billing staffs. In addition, during CYs 2003–2005, the Medicare Multi-Carrier Claims System and the CMS

Common Working File did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider overpayments.²

RECOMMENDATIONS

We recommend that HealthNow:

- recover the \$125,402 overpayment,
- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005, and
- use the results of this audit in its provider education activities.

HEALTHNOW NEW YORK, INC.’S COMMENTS

In its January 15, 2008, comments on the draft report, HealthNow agreed with our recommendations. HealthNow’s comments are included as the Appendix.

²The carrier sends a “Medicare Summary Notice” to the beneficiary after the provider files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX



33 Lewis Road · PO Box 5200
Binghamton, NY 13902-5200
607-766-6000

January 15, 2008

Mr. James P. Edert
Regional Inspector General for Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Report Number: A-02-07-01042

Dear Mr. Edert:

This letter is in response to the draft report number A-02-07-01042 entitled "Review of High-Dollar Payments for Medicare Part B Claims Processed by HealthNow New York Inc, for the period January 1, 2003, through December 31, 2005" as referenced in your letter dated January 2, 2008.

The following provides a status on each of the recommendations outlined in the draft:

OIG Recommendation: Recover the \$125,402 overpayment

HealthNow New York Response: Overpayment letters and full claim adjustments were initiated on July 20, 2007, for the 11 claims identified in the report. As of the date of this letter, we have recovered 100% of the funds identified.

OIG Recommendation: Consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY2005

HealthNow New York Response: We have requested an electronic report identifying the universe of claims paid in CY2006 in excess of \$10,000. We will review and analyze the report, once received, and agree on next steps based on resource availability. Since the Medically Unlikely edits were implemented in January 2007, we will limit our review to CY 2006.

In addition, we will develop an edit to suspend claims with a billed dollar amount over \$10,000. We will develop these claims to verify the quantity billed is accurate. We will then monitor the edit and provider responses quarterly to determine the edit effectiveness moving forward.

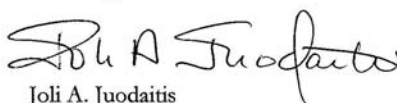
Mr. James P. Edert
January 15, 2008
Page 2

OIG Recommendation: Use the results of this audit in its provider education activities

HealthNow New York Response: We have forwarded the report to our Manager, Provider Education and Training, for inclusion in future provider education initiatives.

We appreciate the opportunity to respond. If you have any questions, please contact me at (607) 766-6325.

Sincerely,

A handwritten signature in black ink, appearing to read "Joli A. Juodaitis". The signature is fluid and cursive, with the first letters of each word being capitalized and prominent.

Joli A. Juodaitis
Managing Director

JAJ/vag