DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

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

May 5, 2008

Report Number: A-02-07-01044

Mr. Jim Elmore
Regional Vice President, Contract Administration
National Government Services
8115 Knue Road
Indianapolis, IN 46250

Dear Mr. Elmore:

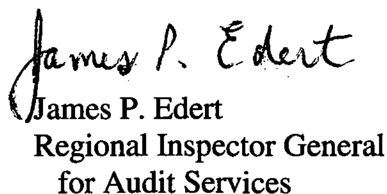
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Medicare Part B Claims Processed by National Government Services for New Jersey Providers for the Period January 1, 2003, Through December 31, 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 do not hesitate to call me, or contact Brenda M. Ryan, Audit Manager, at (212) 264-4677 or through e-mail at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-07-01044 in all correspondence.

Sincerely,



James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nan Foster Reilly, Acting 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 NATIONAL GOVERNMENT SERVICES FOR NEW JERSEY PROVIDERS FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

May 2008
A-02-07-01044

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General 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).

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 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. In addition, pursuant to 42 U.S.C. § 1395u(b)(6)(B) and (E), skilled nursing facilities are required to bill for all services provided to a facility resident. CMS guidance also requires carriers to pay for physician services based on a fee schedule.

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.

National Government Services (formerly Empire Medicare Services) is the Medicare Part B carrier for about 38,000 providers in New Jersey. During calendar years (CY) 2003-2005, National Government Services processed more than 94 million Part B claims, 1,265 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether National Government Services' high-dollar Medicare payments to Part B providers in New Jersey were appropriate.

SUMMARY OF FINDING

Of the 100 high-dollar payments in our statistical sample that National Government Services made to providers, 93 were appropriate. However, National Government Services overpaid providers $108,989 for the remaining seven payments. Providers refunded four of the overpayments, totaling $96,238, prior to our fieldwork, and one of the overpayments, totaling $10,030, during our fieldwork. Two overpayments, totaling $2,721, remained outstanding.

National Government Services made the overpayments because providers incorrectly claimed excessive units of service for three claims, services not separately billable for one claim, and a service not delivered for one claim. For two additional claims, the carrier inaccurately entered the payment rate. 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.

Based on the sample results, for our 3-year audit period, we estimate that National Government Services made 89 overpayments, totaling $1,378,708, to providers in New Jersey for Part B services.

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $2,721 in overpayments,
- review the remaining 1,165 high-dollar claims processed during CYs 2003-2005 with potential overpayments estimated at $1,269,719 ($1,378,708 less $108,989) and work with the providers that claimed these services to recover any overpayments,
- 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.

NATIONAL GOVERNMENT SERVICES' COMMENTS

In its April 29, 2008, comments on the draft report, National Government Services agreed with our recommendations. National Government Services' comments appear in their entirety in Appendix C.

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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 (42 U.S.C. § 1395u(b)) 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. In addition, pursuant to 42 U.S.C. § 1395u(b)(6)(B) and (E), skilled nursing facilities are required to bill for all services provided to a facility resident.[2] CMS guidance also requires carriers to pay for physician services based on a fee schedule.

During calendar years (CY) 2003-2005, providers nationwide submitted approximately 2.4 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.

National Government Services

National Government Services (formerly Empire Medicare Services) is the Medicare Part B carrier for about 38,000 providers in New Jersey. During CYs 2003-2005, Empire Medicare Services used the Medicare Multi-Carrier Claims System to process more than 94 million Part B claims, 1,265 of which resulted in high-dollar payments.

In January 2007, Empire Medicare Services was one of five companies combined to become National Government Services.[3] The name "National Government Services" used throughout this report refers to the carrier formerly known as Empire Medicare Services.

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[1]The 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.

[2]Skilled nursing facilities are paid under a prospective payment system (PPS). The rate includes costs such as those for administering medication.

[3]AdminaStar Federal; Anthem Health Plans of New Hampshire, Inc.; Associated Hospital Service, Empire Medicare Services; and United Government Services, LLC combined operations and became National Government Services.

"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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether National Government Services' high-dollar Medicare payments to Part B providers in New Jersey were appropriate.

Scope

We reviewed a statistical sample of 100 high-dollar payments, totaling $2,590,748, from the 1,265 high-dollar payments, totaling $32,915,778, that National Government Services processed during CYs 2003-2005.

We limited our review of National Government Services' internal controls to those applicable to the 100 sampled 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 from June to December 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;
- selected a simple random sample of 100 payments from the universe of 1,265 high-dollar payments processed by National Government Services during CYs 2003-2005, as detailed in Appendix A;

- reviewed available Common Working File claims histories for each of the 100 sample items 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 for our 100 sample claims;

- coordinated our claim review, including the calculation of any overpayments, with National Government Services; and

- estimated the number and dollar impact of the overpayments in the total population of 1,265 high-dollar payments.

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 finding and conclusions based on our audit objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the 100 high-dollar payments in our statistical sample that National Government Services made to providers, 93 were appropriate. However, National Government Services overpaid providers $108,989 for the remaining seven payments. Providers refunded four of the overpayments, totaling $96,238, prior to our fieldwork, and one of the overpayments, totaling $10,030, during our fieldwork. Two overpayments, totaling $2,721, remained outstanding.

National Government Services made the overpayments because providers incorrectly claimed excessive units of service for three claims, services not separately billable for one claim, and a service not delivered for one claim. For two additional claims, the carrier inaccurately entered the payment rate. 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.

Based on the sample results, for our 3-year audit period, we estimate that National Government Services made 89 overpayments, totaling $1,378,708, to providers in New Jersey for Part B services. Details of our sample results and estimates are shown in Appendix B.

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."

Pursuant to 42 U.S.C. § 1395u(b)(6)(B) and (E), skilled nursing facilities are required to bill for all services provided to a facility resident. In addition, the Medicare Claims Processing Manual, Chapter 12, section 20, requires carriers to pay for physician services based on a fee schedule.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

For three overpayments, totaling $43,845, providers billed for excessive units of service:

- One provider billed 20 units of service (spinal magnetic resonance imaging) for 1 unit delivered. The provider stated that it had entered the incorrect number of services delivered. As a result, National Government Services paid the provider $19,669 when it should have paid $983, an overpayment of $18,686. The provider refunded the overpayment prior to our fieldwork.

- One provider billed six units of service (doses of a chemotherapy drug) for one unit delivered. The provider stated that it had miscalculated the dosage administered. As a result, National Government Services paid the provider $12,059 when it should have paid $2,029, an overpayment of $10,030. The provider refunded the overpayment during our fieldwork.

- One provider billed 25 units of service (sessions of radiation therapy) for 5 units delivered. The provider stated that it had entered the incorrect number of sessions furnished. As a result, National Government Services paid the provider $19,404 when it should have paid $4,275, an overpayment of $15,129. The provider refunded the overpayment prior to our fieldwork.

For one overpayment, totaling $46,943, the provider billed for services not separately billable:

- The provider billed 45,312 units of service (doses of a hemophilia drug) for a patient who was in a skilled nursing facility. The provider stated that, at the time of the drug shipment, it was not aware that the patient was in a skilled nursing facility. As a result, National Government Services paid the provider $46,943 when it should have paid nothing, an overpayment of $46,943.[4] The provider refunded the overpayment (after being notified about it by the carrier) prior to our fieldwork.

For one overpayment, totaling $24, a provider billed for a service not delivered:

- The provider billed for one unit of service (an intravenous infusion of a blood disorder drug) not delivered. The provider stated that it mistakenly entered the service as part of a larger claim. As a result, National Government Services paid the provider $10,109 for

[4]The cost of the drugs were already included in the PPS payment made to the facility.

the claim when it should have paid $10,085, an overpayment of $24. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

For the remaining two overpayments, totaling $18,177, National Government Services' reimbursement staff applied incorrect payment rates when processing claims:

- The carrier entered a payment rate of $21,500 instead of $2,150 for processing, preserving and transporting corneal tissue. The carrier stated that it processed the claim manually because the claim processing system lacked a price code for the service. As a result, National Government Services paid the provider $18,033 when it should have paid $2,553, an overpayment of $15,480. The provider refunded the overpayment prior to our fieldwork.

- The carrier paid a provider for 25,920 units of service (doses of a hemophilia drug) using an incorrect fee schedule amount. The carrier stated that the overpayment was due to a computer systems error. As a result, National Government Services paid the provider $20,737 when it should have paid $18,040, an overpayment of $2,697. 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. The carrier attributed the incorrect claims to a clerical error made by its reimbursement staff and a computer system error. 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 these types of erroneous claims. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[5]

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $2,721 in overpayments,

- review the remaining 1,165 high-dollar claims processed during CYs 2003-2005 with potential overpayments estimated at $1,269,719 ($1,378,708 less $108,989) and work with the providers that claimed these services to recover any overpayments,

- 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.

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[5]The 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.

NATIONAL GOVERNMENT SERVICES' COMMENTS

In its April 29, 2008, comments on the draft report, National Government Services agreed with our recommendations. National Government Services' comments appear in their entirety in Appendix C.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether National Government Services' high-dollar Medicare payments to New Jersey providers for Part B services were appropriate.

POPULATION

The population was all Part B paid claims with service dates in calendar years 2003 through 2005 for which National Government Services paid providers $10,000 or more.

SAMPLING FRAME

The sampling frame was an Access file containing 1,265 Part B paid claims with service dates in calendar years 2003 through 2005 for which National Government Services paid a provider $10,000 or more. The total reimbursement for the 1,265 Part B paid claims was $32,915,778. The paid claims data was extracted from the Centers for Medicare & Medicaid Services National Claims History File.

SAMPLE UNIT

The sample unit was a Part B claim paid to a provider for services rendered to a Medicare beneficiary during the audit period. One claim may have contained multiple lines of service.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample size of 100 high-dollar Part B claims.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services Statistical Sampling software, RAT-STATS 2007, version 1. We used the random number generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the claims in our sampling frame and selected the sequential numbers that correlated to the random numbers. We then created a list of 100 sampled items.

CHARACTERISTICS TO BE MEASURED

We based our determination as to whether each sampled high-dollar payment was appropriate on Federal regulations and guidance. Specifically, if at least one of the following characteristics was met, we considered the payment under review inappropriate:

- The dosage or the number of units of service was incorrectly billed.
- The provider indicated that the procedure billed was not performed or that the procedure code billed did not accurately represent the service(s) rendered.
- The unit payment amount exceeded the unit allowed amount on the Medicare fee schedule.

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We estimated the total number of high-dollar payments that were inappropriate and the dollar impact of the inappropriate payments.

SAMPLE RESULTS AND ESTIMATES

The results of our review of the 100 high-dollar Part B payments were as follows:

Sample Details and Results

No. of Payments in Universe	Value of Universe	Sample Size	Value of Sample Payments	No. of Overpayments	Value of Overpayments
1,265	$32,915,778	100	$2,590,748	7	$108,989

Estimates of Sample Results
Precision at the 90-Percent Confidence Level

	Estimated No. of Inappropriate High-Dollar Payments	Estimated Value of Inappropriate High-Dollar Payments
Point Estimate	89	$1,378,708
Lower Limit	44	267,195
Upper Limit	158	2,490,222

Medicare

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A CMS Contracted Agent

April 29, 2008

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

RE: Response to Draft Report Number A-02-07-01044

Dear Mr. Edert:

This letter is in response to the above referenced draft report entitled "Review of High Dollar Payments for Medicare Part B Claims Processed by National Government Services for New Jersey Providers for the Period January 1, 2003 through December 31, 2005."

We agree with the audit recommendations noted in the draft report. We have already recovered the $2,721 in overpayments identified in the recommendations. We will also review the remaining 1,165 high dollar claims processed during calendar years 2003 – 2005 upon receipt of that data and will recover any overpayments in accordance with the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOMs) instructions, unless directed otherwise by CMS. In addition, we will provide further outreach and education to providers on the issues identified in the report.

We will also identify and recover any additional overpayments made for high-dollar Part B claims paid after calendar year 2005 and prior to the medically unlikely edits being implemented in January 2007.

Thank you for the opportunity to respond to the draft report. If you have any additional questions, please feel free to contact Cheryl Leissring, Claims Director, at 414-459-5884.

Sincerely,

Christine Beard
Regional Vice President, Claims and Operations