DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

JUN 30 2008

Report Number: A-04-07-06021

Ms. Sandy Coston, President
First Coast Service Options, Inc.
532 Riverside Avenue, 20T
Jacksonville, Florida 32202

Dear Ms. Coston:

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 Part B Services Processed by First Coast Service Options, Inc. for the Period January 1, 2004, Through December 31, 2006." 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.

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If you have any questions or comments about this report, please do not hesitate to call me or contact Mary Ann Moreno, Audit Manager, at (904) 232-2688 or through e-mail at Mary.Moreno@oig.hhs.gov. Please refer to report number A-04-07-06021 in all correspondence.

Sincerely,

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:
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, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR PART B SERVICES PROCESSED BY FIRST COAST SERVICE OPTIONS, INC. FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2006

Daniel R. Levinson
Inspector General

June 2008
A-04-07-06021

Office of Inspector General

http://oig.hhs.gov

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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.

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.

First Coast Service Options, Inc. (First Coast) is the Medicare Part B carrier for providers in Florida. During calendar years (CY) 2004–2006, Florida processed more than 225 million Part B claims, 9,533 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDING

Of the 300 high-dollar payments in our random samples of claims that First Coast paid to providers, 299 were appropriate. First Coast overpaid a provider $12,356 for the remaining claim. We did not identify a sufficient number of improper payments in our samples to allow us to make a reliable estimate of the improper payments in the population.

First Coast made the overpayment in CY 2005 because the provider incorrectly claimed excessive units of service. 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.

RECOMMENDATION

We recommend that First Coast recover the $12,356 overpayment.

FIRST COAST SERVICE OPTIONS COMMENTS

In written comments on our draft report, First Coast agreed to recover the $12,356 overpayment. First Coast's comments appear in their entirety as Appendix D.

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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 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 approximately 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.

First Coast Service Options, Inc.

First Coast Service Options, Inc. (First Coast) is the Medicare Part B carrier for providers in Florida. During CYs 2004–2006, Florida processed more than 225 million Part B claims, 9,533 of which resulted in payments of $10,000 or more (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.

[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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed random samples of 300 high-dollar payments totaling $5,712,536 from the 9,533 high-dollar payments totaling $158,671,960 that First Coast processed during CYs 2004–2006.

We limited our review of First Coast's internal controls to those applicable to the 300 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 at First Coast's offices in Jacksonville, Florida, from May 2007 to May 2008.

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, as detailed in Appendixes A, B, and C, three random samples of 100 of these claims totaling $5,712,536 ($1,621,103 from CY 2004; $1,771,869 from CY 2005; and $2,319,564 from CY 2006);

- 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 First Coast.

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

FINDING AND RECOMMENDATION

Of the 300 high-dollar payments in our random samples of claims that First Coast paid to providers, 299 were appropriate. First Coast overpaid a provider $12,356 for the remaining claim. We did not identify a sufficient number of improper payments in our samples to allow us to make a reliable estimate of the improper payments in the population.

First Coast made the overpayment in CY 2005 because the provider incorrectly claimed excessive units of service. 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 PAYMENT

For the overpayment totaling $12,356, the provider incorrectly billed First Coast for excessive units of service. The provider inadvertently billed 200 units of service (injection, octreotide) for 20 units delivered. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

The provider attributed the incorrect claim to a clerical error made by billing staff. In addition, during CYs 2003–2005, the VIPS Medicare System, 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]

RECOMMENDATION

We recommend that First Coast recover the $12,356 overpayment.

FIRST COAST SERVICE OPTIONS COMMENTS

In its June 16, 2008, written comments on our draft report, First Coast agreed to initiate its standard overpayment recovery procedures to recover the $12,356 overpayment. First Coast's comments appear in their entirety as Appendix D.

[2]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.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY - CALENDAR YEAR 2004

Objective

Our objective was to determine whether First Coast Service Options, Inc.'s (First Coast) high-dollar Medicare payments to Part B providers were appropriate.

Population

The population consisted of 2,462 Part B claims with service dates in calendar year 2004 for which First Coast paid providers $10,000 or more. The 2,462 claims totaled $42,513,938.

Sampling Unit

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

Sampling Design

We used a simple random sample.

Sample Size

The sample size was 100 Part B claims.

Source of Random Numbers

The source of the random numbers was the Office of Inspector General, Office of Audit Services statistical sampling software, version 1, dated 2007. We used the random number generator for our simple random sample.

Method of Selecting Sample Items

We sequentially numbered Part B claims First Coast processed and paid to Medicare providers in our sampling frame. After generating 100 random numbers, we correlated each random number to the population number and selected that population number for our sample.

APPENDIX B

SAMPLING METHODOLOGY - CALENDAR YEAR 2005

Objective

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

Population

The population consisted of 6,333 Part B claims with service dates in calendar year 2005 for which First Coast paid providers $10,000 or more. The 6,333 claims totaled $99,931,201.

Sampling Unit

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

Sampling Design

We used a simple random sample.

Sample Size

The sample size was 100 Part B claims.

Source of Random Numbers

The source of the random numbers was the Office of Inspector General, Office of Audit Services statistical sampling software, version 1, dated 2007. We used the random number generator for our simple random sample.

Method of Selecting Sample Items

We sequentially numbered Part B claims First Coast processed and paid to Medicare providers in our sampling frame. After generating 100 random numbers, we correlated each random number to the population number and selected that population number for our sample.

APPENDIX C

SAMPLING METHODOLOGY - CALENDAR YEAR 2006

Objective

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

Population

The population consisted of 738 Part B claims with service dates in calendar year 2006 for which First Coast paid providers $10,000 or more. The 738 claims totaled $16,226,821.

Sampling Unit

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

Sampling Design

We used a simple random sample.

Sample Size

The sample size was 100 Part B claims.

Source of Random Numbers

The source of the random numbers was the Office of Inspector General, Office of Audit Services statistical sampling software, version 1, dated 2007. We used the random number generator for our simple random sample.

Method of Selecting Sample Items

We sequentially numbered Part B claims First Coast processed and paid to Medicare providers in our sampling frame. After generating 100 random numbers, we correlated each random number to the population number and selected that population number for our sample.

Sandy Coston
CEO & President
First Coast Service Options, Inc.
Sandy.Coston@fcso.com

June 16, 2008

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

Reference: A-04-07-06021

Dear Mr. Barbera:

We received the Department of Health and Human Services, Office of Inspector General's draft report entitled, "Review of High-Dollar Payments for Medicare Part B Claims Processed by First Coast Service Options, Inc." for the period January 1, 2004 through December 31, 2006 and have reviewed the finding and recommendation.

First Coast Service Options, Inc. (FCSO) strives to safeguard against inappropriate Medicare Trust Fund expenditures. The claim in question was paid as submitted by the provider with a higher unit of service than was delivered.

The draft report contained the following:

Recommendation:

FCSO recover the $12,356 overpayment.

FCSO Response:
FCSO will initiate its standard overpayment recovery procedures to recover the overpayment identified by the OIG.

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We appreciate the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding our response, please contact Mr. Gregory W. England at (904) 791-8364.

Sincerely,

Sandy Coston

Sandy Coston