DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Region IX
Office of Audit Services
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

Report Number: A-09-07-00059

FEB 1 9 2008

Ms. Sandra Miller
President
National Government Services
8115 Knue Road
Indianapolis, Indiana 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 Excessive Payments for Outpatient Claims Processed by National Government Services for Calendar Years 2003 Through 2005 – California Providers." We will forward a copy of this report to the HHS action official noted below.

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 direct them to the HHS action official. Please refer to report number A-09-07-00059 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF EXCESSIVE PAYMENTS FOR OUTPATIENT CLAIMS PROCESSED BY NATIONAL GOVERNMENT SERVICES FOR CALENDAR YEARS 2003 THROUGH 2005

CALIFORNIA PROVIDERS

Daniel R. Levinson
Inspector General

February 2008
A-09-07-00059

Office of Inspector General

http://oig.hhs.gov

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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Notices

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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 fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process claims. The Common Working File can detect certain improper payments during prepayment validation.

Medicare guidance requires hospitals to claim outpatient services using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and to report units of service as the number of times that a service or procedure was performed.

During our audit period (calendar years (CY) 2003 through 2005), United Government Services was the fiscal intermediary for California. United Government Services processed approximately 15.7 million outpatient claims during this period, 59 of which resulted in payments of $50,000 or more (high-dollar payments). In January 2007, National Government Services assumed the business operations of United Government Services.

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that National Government Services made to hospitals for outpatient services were appropriate.

SUMMARY OF RESULTS

Of the 59 high-dollar payments that National Government Services made for outpatient services for CYs 2003 through 2005, 18 were appropriate. The remaining 41 payments included overpayments totaling $3,463,740. For all 41 claims, the hospitals inappropriately overstated the units of service, occasionally in combination with incorrect HCPCS codes. The hospitals have already refunded the overpayments; comments we received from some hospitals indicated that they were analyzing their billing systems and procedures and would provide training and make system enhancements as appropriate.

National Government Services made the overpayments because it did not have sufficient prepayment or postpayment controls to identify aberrant payments at the claim level. The prepayment edits were limited to screening claims exceeding the threshold of $50,000 in reported charges. Because these edits focused on charges rather than payment amounts, claims with payment amounts of $50,000 or more that had charges below the threshold were not identified, allowing inappropriate payments to go undetected. Further, the Common Working File lacked prepayment edits to detect and prevent excessive payments.

On January 3, 2006, after our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. The edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

CONCLUSION

Because National Government Services has already recovered the overpayments from the hospitals and implemented a Fiscal Intermediary Standard System edit to suspend high-dollar outpatient claims for prepayment review, we have not included any recommendations in this report.

National Government Services officials agreed with the results of our audit but did not provide formal written comments.

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INTRODUCTION

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) administers the program.

Medicare Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries 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 intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments during prepayment validation.

In calendar years (CY) 2003 through 2005, fiscal intermediaries processed and paid approximately 410 million outpatient claims, 1,243 of which resulted in payments of $50,000 or more (high-dollar payments).

Claims for Outpatient Services

Medicare guidance requires hospitals to claim outpatient services using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and to report units of service as the number of times that a service or procedure was performed.

National Government Services

During our audit period (CYs 2003 through 2005), United Government Services was the fiscal intermediary for California. United Government Services processed approximately 15.7 million outpatient claims during this period, 59 of which resulted in high-dollar payments. In January 2007, National Government Services assumed the business operations of United Government Services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that National Government Services made to hospitals for outpatient services were appropriate.

Scope

We reviewed the 59 high-dollar payments for outpatient claims that National Government Services processed during CYs 2003 through 2005. We limited our review of National Government Services's internal controls to those applicable to the 59 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.

We conducted fieldwork from April through August 2007. Our fieldwork included contacting National Government Services, located in Milwaukee, Wisconsin, and the hospitals that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient 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;
- contacted the hospitals that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect and whether the hospitals agreed that refunds were appropriate;
- validated with National Government Services that overpayments occurred and refunds were appropriate; and
- inspected documents related to $3,463,740 recovered by National Government Services.

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 objectives.

RESULTS OF AUDIT

Of the 59 high-dollar payments that National Government Services made for outpatient services for CYs 2003 through 2005, 18 were appropriate. The remaining 41 payments included overpayments totaling $3,463,740. For all 41 claims, the hospitals inappropriately overstated the units of service, occasionally in combination with incorrect HCPCS codes. The hospitals have already refunded the overpayments; comments we received from some hospitals indicated that they were analyzing their billing systems and procedures and would provide training and make system enhancements as appropriate.

National Government Services made the overpayments because it did not have sufficient prepayment or postpayment controls to identify aberrant payments at the claim level. In addition, neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2003 through 2005 to detect and prevent excessive payments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. CMS's "Medicare Claims Processing Manual," Publication 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."

Section 3700 of the "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

National Government Services made 41 overpayments totaling $3,463,740 as a result of hospital reporting of excessive units of service. Billing errors typically resulted from clerical or system errors that inadvertently overstated the units of service, some of which resulted in large overpayments. The overpayment amounts for the 41 incorrectly paid claims ranged from $34,841 to $685,588. None of the incorrect claims resulted in a net underpayment.

The following examples illustrate the overstated units of service:

- A hospital submitted two claims with multiple units of service rather than only one unit of service provided, which resulted in a total overpayment of $190,295.

- A large medical center analyzed the 11 overpaid claims that we referred and discovered a mapping error in its pharmacy billing system that miscoded HCPCS codes for two drugs. This miscoding overstated units of service, which resulted in a total overpayment of

$575,892 for the 11 claims. In addition to refunding the amount, the provider initiated corrective action to correct the pharmacy system.

CAUSES OF OVERPAYMENTS

During CYs 2003 through 2005, National Government Services made the overpayments because it did not have sufficient prepayment or postpayment controls to identify aberrant payments at the claim level. The prepayment edits were limited to screening claims exceeding the threshold of $50,000 in reported charges. Because these edits focused on charges rather than payment amounts, claims with payment amounts of $50,000 or more that had charges below the threshold were not identified, allowing inappropriate payments to go undetected. Further, the Common Working File lacked prepayment edits to detect and prevent excessive payments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[1]

FISCAL INTERMEDIARY PREPAYMENT EDIT

On January 3, 2006, after our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. The edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

CONCLUSION

Because National Government Services has already recovered the overpayments from the hospitals and implemented a Fiscal Intermediary Standard System edit to suspend high-dollar outpatient claims for prepayment review, we have not included any recommendations in this report.

National Government Services officials agreed with the results of our audit but did not provide written comments.

[1]The fiscal intermediary sends an "Explanation of Medicare Benefits" notice to the beneficiary after the hospital 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.