DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

October 10, 2008

Report Number: A-05-08-00029

Ms. Sandy 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 High-Dollar Payments for Medicare Part B Claims Processed by National Government Services for Indiana and Kentucky Providers 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.

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, this report 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 Steve Slamar, Audit Manager at (312) 353-7905 or through e-mail at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-07-00029 in all correspondence.

Sincerely,

Marc Gustafson
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 MEDICARE PART B CLAIMS PROCESSED BY NATIONAL GOVERNMENT SERVICES FOR INDIANA AND KENTUCKY PROVIDERS FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2006

Daniel R. Levinson
Inspector General

October 2008
A-05-08-00029

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.

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 is a Medicare Part B carrier for the providers in Indiana and Kentucky. During calendar years (CY) 2004 through 2006, National Government Services processed more than 97 million Part B claims, 622 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that National Government Services made to Medicare Part B providers were appropriate.

SUMMARY OF FINDINGS

Of 100 sampled high-dollar payments that National Government Services made to providers, 95 were appropriate. However, National Government Services overpaid a provider $11,903 for one claim and underpaid four providers $5,946 for four claims.

Providers incorrectly reported units of service for two claims, and the carrier inaccurately entered allowed amounts for three claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004 through 2006 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $11,903 for the one overpayment,
- reimburse the $5,946 for the four underpayments, and
- consider identifying and reviewing additional high-dollar Part B claims paid after CY 2006.

NATIONAL GOVERNMENT SERVICES COMMENTS

In its comments on our draft report, National Government Services agreed with our recommendations. National Government Services' 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 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) 2004 through 2006, providers nationwide submitted approximately 2.4 billion claims to carriers. Of these, 31,576 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

During our audit period (CYs 2004 through 2006), AdminaStar Federal was a Medicare Part B carrier for the providers in Indiana and Kentucky. In January 2007, National Government Services assumed the business operations of AdminaStar Federal.

National Government Services used the Viable Information Processing System (VIPS) Medicare System to process claims until November 2004 and began processing new claims using the Medicare Multi-Carrier Claims System in December 2004.[2] During CYs 2004 through 2006, National Government Services processed more than 97 million Part B claims, 622 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

[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]CMS required carriers to transition to the Medicare Multi-Carrier Claims System beginning in 2002. Before that time, carriers could use either the VIPS Medicare System or the Medicare Multi-Carrier Claims System.

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 high-dollar Medicare payments that National Government Services made to Part B providers were appropriate.

Scope

We reviewed a statistical sample of 100 high dollar-payments, totaling $3,272,325, from 622 high-dollar payments, totaling $22,038,387, that National Government Services processed for CYs 2004 through 2006.

We limited our review of National Government Services' internal controls to those applicable to the 100 sample 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 conducted our fieldwork from January through June 2008. Our fieldwork included contacting National Government Services and the providers that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to determine the population of Medicare Part B claims with high-dollar payments for 2004 through 2006;
- selected a simple random sample of 100 high-dollar payments using the OAS statistical software and contacted providers to determine whether:
    - the claims had been cancelled or superseded by revised claims or the payments remained outstanding at the time of our fieldwork and
    - the sampled claims were billed correctly and, if not, why the claims were billed incorrectly; and

- coordinated our claim review, including the calculation of any inappropriate payments, with 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 objective.

FINDING AND RECOMMENDATIONS

Of 100 sampled high-dollar payments that National Government Services made to providers, 95 were appropriate. However, National Government Services overpaid a provider $11,903 for one claim and underpaid four providers $5,946 for four claims.

Providers incorrectly reported units of service for two claims, and the carrier inaccurately entered allowed amounts for three claims. In addition, the Medicare claim processing system did not have sufficient edits in place 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

National Government Services overpaid a provider $11,903 for one claim and underpaid four providers $5,946 for four claims.

- One provider reported 300 units of service for a chemotherapy drug but medical records indicated that only 30 units were delivered. The provider stated that the error was a data entry error. As a result, National Government Services paid to the provider $13,351 when it should have paid $1,448, a $11,903 overpayment.

- One provider reported two units of service (implantable neurostimulator electrodes) but 16 units were delivered. The provider stated that the units were not reported due to a data entry error. As a result, National Government Services paid the provider $12,622 when it should have paid $16,884, a $4,262 underpayment.

- One provider submitted a claim for which National Government Services entered into its automated payment system an incorrect allowed amount of $13,756 instead of the correct

allowed amount of $15,756. As a result, National Government Services paid the provider $11,005 when it should have been paid $12,605, a $1,600 underpayment.[3]

- One provider submitted a claim for which National Government Services entered into its automated payment system an incorrect allowed amount of $33,600 instead of the correct allowed amount of $33,660. As a result, National Government Services paid the provider $26,880 when it should have been paid $26,928, a $48 underpayment.[3]

- One provider submitted a claim for which National Government Services entered into its automated payment system an incorrect allowed amount of $77,927 instead of the correct allowed amount of $77,972. As a result, National Government Services paid the provider $62,342 when it should have paid $62,378, a $36 underpayment.[3]

Providers attributed the incorrect units of service to clerical errors made by their billing staffs for two payments, and the carrier attributed the incorrect allowed amounts to clerical errors made by its reimbursement staff for three payments. In addition, during the CYs 2004 through 2006, 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 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.[4]

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $11,903 for the one overpayment,

- reimburse the $5,946 for the four underpayments, and

- consider identifying and reviewing additional high-dollar Part B claims paid after CY 2006.

NATIONAL GOVERNMENT SERVICES COMMENTS

In its comments on our draft report, National Government Services agreed with our recommendations. National Government Services' comments are included in their entirety as the Appendix**.**

[3]The paid amounts represented 80 percent of the allowed amounts. The remaining 20 percent represented the beneficiary's coinsurance.

[4]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.

APPENDIX

National Government Services.

National Government Services, Inc.
8115 Knue Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

Medicare

Beneficiary: 1-800-MEDICARE (1-800-633-4227)
Provider: 866-250-5665

September 22, 2008

Mr. Marc L. Gustafson
Regional Inspector General for Audit Services
Office of Inspector General, Region V
233 North Michigan Avenue
Chicago, IL 60601

RE: Response to Draft Report Number A-05-08-00029

Dear Mr. Gustafson:

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 Indiana and Kentucky Providers for the Period January 1, 2004 through December 31, 2006."

We agree with the audit recommendations noted in the draft report. We have already processed all of the claims adjustments related to the overpayments with the exception of one for an overpayment of $48, which is in process. In addition, we have processed the claims adjustments for the $5,946 in underpayments. We will consider identifying and reviewing additional high-dollar Part B claims paid after CY 2006 based on the results of a sample of claims from this time period.

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,

David Crowley (ms)
David Crowley
Staff Vice President
Claims Management

cc: Cheryl Leissring, Claims Director

CMS
CENTERS for MEDICARE & MEDICAID SERVICES