DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Office of Audit Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102

JAN 14 2005

Report Number: A-09-04-00056

Ms. Anne Bockhoff-Dalton
Vice President
National Heritage Insurance Company
Medicare Administrative Services
75 Sgt. William B. Terry Drive
Hingham, Massachusetts 02043

Dear Ms. Bockhoff-Dalton:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General final report entitled "Review of Claims for Care Plan Oversight Services Paid More Than $150 by National Heritage Insurance Company for Calendar Years 2001 through 2003." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. We request that you respond to the HHS action 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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Please refer to report number A-09-04-00056 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
75 Hawthorne Street, 4th Floor
San Francisco, California 94105

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CLAIMS FOR CARE PLAN OVERSIGHT SERVICES PAID MORE THAN $150 BY NATIONAL HERITAGE INSURANCE COMPANY FOR CALENDAR YEARS 2001 THROUGH 2003

JANUARY 2005
A-09-04-00056

Office of Inspector General

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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

The Centers for Medicare & Medicaid Services (CMS) contracts with carriers for the administration of the Medicare Part B program. Part B covers physician services, including care plan oversight (CPO) services, and other health care supplier services not covered by Part A. The CPO services include physician certification and recertification for home health agency services, and care plan supervision of patients receiving home health agency or hospice services under an approved plan of care.

A CPO certification service can be billed only for an initial 60-day plan-of-care period. After the initial certification period, a CPO recertification service can be billed once every 60 days. The CPO supervision service should be billed monthly, and the physician should be paid for only 1 unit of service per claim when the physician provided at least 30 minutes of qualified CPO supervision services during the calendar month. Payment for CPO services is based on the lesser of the Medicare physician fee schedule amount or the billed amount.

National Heritage Insurance Company (NHIC) is the Medicare carrier for beneficiaries who receive Part B services in the State of California. For calendar years (CYs) 2001 through 2003, we identified 115 CPO claims in California for which NHIC paid more than $150.[1] We used $150 as the threshold because it exceeded the fee schedule allowance for an individual CPO service in any geographic area in California.

OBJECTIVE

Our objective was to determine whether CPO claims for which NHIC paid more than $150 were billed and paid in accordance with Medicare requirements.

SUMMARY OF FINDING

For CYs 2001 through 2003, CPO claims for which NHIC paid more than $150 were not billed or paid in accordance with Medicare requirements. Specifically, NHIC paid a total of $22,663 for 115 CPO claims that were incorrectly billed with more than 1 unit of service. Physicians who billed these services should have been paid a total of $7,863 based on 1 unit of service and the physician fee schedule amounts allowed for these services. As a result, 14 California physicians were overpaid $14,800. These overpayments occurred because:

- physicians or physician billing contractors misunderstood the Medicare billing requirements for CPO services or incorrectly billed due to computer software and clerical errors, and

- NHIC did not have controls to detect CPO claims billed with more than 1 unit of service.

[1] A claim identified in our analysis represents a service line on a claim for CPO services provided to a beneficiary for which Medicare paid a physician more than $150.

RECOMMENDATIONS

We recommend that NHIC:

- recover the $14,800 in overpayments for CPO services,
- identify and recover Medicare overpayments for CPO claims billed with more than 1 unit of service provided subsequent to our audit period,
- remind physicians of the Medicare billing requirements for CPO services, and
- implement controls to detect CPO claims billed with more than 1 unit of service.

NHIC COMMENTS

In written comments on our draft report, NHIC concurred with our findings and recommendations. Also, NHIC indicated that, in March 2004, it implemented controls to detect CPO claims billed with more than 1 unit of service. NHIC's comments are included in their entirety as an appendix.

INTRODUCTION

BACKGROUND

The Medicare program, established under Title XVIII of the Social Security Act in 1965, provides health insurance to people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. The program is administered by CMS, which contracts with carriers for the administration of the Medicare Part B program. Part B covers physician services, including CPO services, and other health care supplier services not covered by Part A. NHIC is the Medicare carrier for beneficiaries who receive Part B services in California.

There are four types of CPO services that physicians can bill to Medicare:

- certification for Medicare-covered home health services under a home health plan of care,
- recertification for Medicare-covered home health services under a home health plan of care,
- supervision of a patient receiving Medicare-covered services provided by a participating home health agency, and
- supervision of a patient under the care of a Medicare-approved hospice.

As part of an Office of Inspector General nationwide review of CPO services, we identified all CPO claims in California for which Medicare paid more than $150 to a physician. We used $150 as the threshold because this amount exceeded the maximum Medicare fee schedule amount allowed for an individual CPO service in any geographic area in California. Using CYs 2001 through 2003 paid claims data from CMS's National Claims History File, we found that 14 physicians submitted 115 CPO claims for which they were paid more than $150 for each claim.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether CPO claims for which NHIC paid more than $150 were billed and paid in accordance with Medicare requirements.

Scope

We limited our review to determining why physicians and physician billing contractors submitted claims for CPO services with more than 1 unit of service and whether NHIC had controls to identify CPO claims billed with more than 1 unit of service.

We did not determine if the 115 claims were for medically necessary CPO services. Further, we did not assess the overall internal control structure of NHIC. Our internal control review was

limited to obtaining an understanding of NHIC's procedures to detect incorrectly billed CPO services and prevent overpayments.

We performed our review from May through July 2004 and conducted fieldwork at selected physician offices and physician billing contractor offices in California.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare regulations and guidance;
- analyzed the CMS claims data to determine the types of CPO services paid, the number of units claimed, and the physicians who were paid for the services;
- interviewed two physicians and three billing contractors to determine why CPO claims were billed with more than 1 unit of service;
- contacted NHIC officials to determine if there were controls for identifying CPO claims billed with more than 1 unit of service; and
- discussed the results of our review and verified the calculated overpayment of CPO claims with NHIC officials.

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

FINDING AND RECOMMENDATIONS

For CYs 2001 through 2003, CPO claims for which NHIC paid more than $150 were not billed or paid in accordance with Medicare requirements. Specifically, NHIC paid a total of $22,663 for 115 CPO claims that were incorrectly billed with more than 1 unit of service. Physicians who provided these services should have been paid a total of $7,863 based on 1 unit of service and the physician fee schedule amounts allowed for these services. As a result, 14 California physicians were overpaid $14,800. These overpayments occurred because:

- physicians or physician billing contractors misunderstood the Medicare billing requirements for CPO services or incorrectly billed due to computer software and clerical errors, and
- NHIC did not have controls to detect CPO claims billed with more than 1 unit of service.

MEDICARE BILLING REQUIREMENTS

The CPO services include physician certification and recertification for home health agency services, and care plan supervision of patients receiving home health agency or hospice services under an approved plan of care.

CMS provided guidance for CPO certification and recertification services in Program Memorandum, Carriers, Transmittal B-00-65, dated November 21, 2000. In the section addressing physician certification and recertification of home health plans of care, CMS indicated that a CPO certification service could be billed only for an initial 60-day plan-of-care period. A CPO recertification service could be billed after the initial certification period only once every 60 days.

Part 3 of the Medicare Carriers Manual, chapter 15, section 15513 states that physicians may bill for CPO supervision services provided to beneficiaries who are receiving home health or hospice services under an approved plan of care. The manual states that CPO supervision services should be billed monthly, and the physician should be paid for only 1 unit of service when the physician furnished at least 30 minutes of qualified CPO services during the calendar month.

A physician is paid for a CPO service based on the lesser of the actual charges billed or the applicable Medicare physician fee schedule amount.

CPO CLAIMS IMPROPERLY BILLED AND PAID

The CPO claims for which NHIC paid more than $150 were not billed and paid in accordance with Medicare requirements. NHIC paid $22,663 to 14 physicians for 115 CPO claims for services provided during CYs 2001 through 2003. Of the 115 claims, 61 claims were for certification, 52 claims were for recertification, and 2 claims were for supervision services. The 14 physicians incorrectly billed Medicare for the CPO services by submitting claims with more than 1 unit of service.

To calculate the allowed amount for a CPO service, the NHIC Medicare payment system multiplied the appropriate fee schedule amount by the number of service units billed on the claim. The system used the lesser of the calculated amount or the submitted charges as the allowed amount. The 14 physicians who billed more than 1 unit of service on each claim were paid more than the fee schedule amount allowed for CPO services.

For example, one physician submitted a claim for a CPO recertification with 23 units of service. To calculate the allowed amount, NHIC multiplied the fee schedule amount of $67.44 by the 23 units of service billed, for a total of $1,551.12. Since this amount exceeded the physician's submitted charge of $200.00, NHIC used $200.00 as the allowed amount and paid the physician $160.00 after deducting the 20 percent coinsurance amount. The NHIC payment system should have paid $53.95 ($67.44 × 1 unit of service × 80 percent). Therefore, the physician was overpaid $106.05 ($160.00 – $53.95 = $106.05).

We used the Medicare fee schedule to calculate the amount that should have been paid for each of the 115 CPO claims based on 1 unit of service per claim. We found that NHIC overpaid 14 physicians a total of $14,800.

PHYSICIAN BILLING ERRORS

The physicians incorrectly billed for CPO services with more than 1 unit of service per claim because the Medicare billing requirements were misunderstood or because computer software and clerical errors occurred.

Billing Requirements Misunderstood

We interviewed one physician who submitted a claim for a CPO supervision service with 2 units of service. The physician stated that 60 minutes of qualified CPO supervision services were provided within the calendar month of the claim. However, the physician incorrectly interpreted the 60 minutes as representing two 30-minute periods, or 2 units of service.

Another physician submitted 32 claims for CPO recertifications with units of service ranging from 3 to 29. We interviewed the physician's billing contractor and learned that the billing staff had misinterpreted the term "units of service" to mean the number of days between the physician's first and last dates of CPO service within the calendar month.

Computer Software and Clerical Errors

A billing contractor, who provided billing services for 10 of the 14 physicians, indicated that it had a software logic error in its computer billing system. One unit of service was correctly keyed into the system; however, the billing system software converted the 1 unit of service into 10 units of service on the electronic claim submitted to Medicare.

Another billing contractor for one physician submitted a claim for a CPO supervision service with 2 units of service due to a clerical input error.

INADEQUATE PAYMENT CONTROLS AT NHIC

NHIC did not have adequate controls to detect CPO claims billed with more than 1 unit of service. NHIC had a system edit in place to deny more than one CPO supervision service claimed in the same month when two separate claims were submitted. However, NHIC did not have a system edit to identify a claim for a CPO service submitted with more than 1 unit of service.

RECOMMENDATIONS

We recommend that NHIC:

- recover the $14,800 in overpayments for CPO services,

- identify and recover Medicare overpayments for CPO claims billed with more than 1 unit of service provided subsequent to our audit period,

- remind physicians of the Medicare billing requirements for CPO services, and

- implement controls to detect CPO claims billed with more than 1 unit of service.

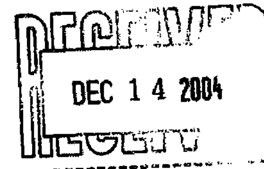
NHIC COMMENTS

In written comments on our draft report, NHIC concurred with our findings and recommendations. Also, NHIC indicated that, in March 2004, it implemented controls to detect CPO claims billed with more than 1 unit of service. NHIC's comments are included in their entirety as an appendix.

APPENDIX

MEDICARE
PART B CARRIER

December 13, 2004



Department of Health & Human Services
Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

Attn: Lori A. Ahlstrand
Regional Inspector General for Audit Services

RE: OIG Audit A-09-04-00056, Review of Claims for Care Plan Oversight Services Paid More than $150 by National Heritage Insurance Company for Calendar Years 2001 through 2003

Subject: Response to November 29, 2004 Draft Report

Dear Ms. Ahlstrand:

The letter is in response to the OIG Audit A-09-04-00056, Review of Claims for Care Plan Oversight Services Paid More than $150 by National Heritage Insurance Company for Calendar Years 2001 through 2003. In brief, NHIC concurs with the findings, and our response to the findings and recommendations is itemized below.

Finding 1: Physicians or physician billing contractors misunderstood the Medicare billing requirements for CPO services or incorrectly billed due to computer software and clerical errors.

NHIC Response
NHIC agrees that some physician or physician billing contractors misunderstood how to properly report the number of CPO services, or had inadequate controls to avoid billing for more services than intended.

Finding 2: NHIC did not have controls to detect CPO claims billed with more than 1 unit of service.

NHIC Response
NHIC concurs that our controls should be strengthened to anticipate the provider billing irregularities. Prior to this audit, controls were in place to deny a CPO service billed for more than one *provider* per month, but not more than one *unit of service* per provider per month.

NHIC
National Heritage Insurance Company
75 SGT WILLIAM B TERRY DR
Hingham, MA 02043
A CMS CONTRACTED CARRIER

Recommendation 1: Recover the $14,800 in overpayments for CPO services

NHIC Response
NHIC will recover the $14,800 in overpayments for CPO services in CY 2001 through 2003. NHIC will initiate an internal review and recover any other similar overpayments found during this period. We anticipate having this completed by April 30, 2005.

Recommendation 2: Identify and recover Medicare overpayments for CPO claims billed with more than 1 unit of service provide subsequent to our audit period.

NHIC Response
NHIC will identify any additional related overpayments which occurred subsequent to the audit period (CY 2004). This will be completed concurrent with our response to Recommendation 1.

Recommendation 3: Remind physicians of the Medicare billing requirements for CPO.

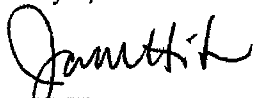
NHIC Response
NHIC will publish a reminder, which will specifically address the "unit of service" issues for each of the codes cited, on our California provider website (http://www.medicarenhic.com/cal_prov/index.shtml), and in our next available provider bulletin (March 2005).

Recommendation 4: Implement controls to detect CPO claims billed with more than 1 unit of service.

NHIC Response
NHIC implemented controls in March of 2004 to detect CPO services billed with more than 1 unit of service. These controls are working as designed.

If you have any questions regarding NHIC corrective actions, please contact Jennifer Otten, Manager of Audits & Controls, at (530) 896-7143.

Thank you,



Jane M. Hite
Director, Business Support
NHIC Medicare Administrative Services

CC: James Underhill, CMS Region IX
Anne Bockhoff Dalton, NHIC
Jennifer Otten, NHIC

ACKNOWLEDGMENTS

This report was prepared under the direction of Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX. Other principal Office of Audit Services staff who contributed include:

Jerry McGee, *Audit Manager*
Yun (Jessica) Kim, *Senior Auditor*
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For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.