DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAY 25 2006

TO: Wynethea Walker
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Excessive Payments for Outpatient Services Processed by Mutual of Omaha (A-01-05-00514)

Attached is an advance copy of our final report on excessive payments for outpatient services processed by Mutual of Omaha during calendar year 2003. We will issue this report within 5 business days. This review was self-initiated as part of a continuing effort to identify excessive overpayments in the Medicare program.

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

Our objective was to determine whether high-dollar Medicare payments that Mutual of Omaha made to providers for outpatient services were appropriate.

In calendar year 2003, Mutual of Omaha processed 54 outpatient claims that had payments of $50,000 or more. Our analysis indicated that providers overstated units of service on 45 claims, resulting in overpayments of $8,275,200. At the start of our fieldwork, providers had refunded $5,466,816, and $2,808,384 remained outstanding. Contrary to Federal guidance, the providers inappropriately overstated the units of service. Mutual of Omaha made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar year 2003 to detect billing errors related to units of service.

We recommend that Mutual of Omaha:

- inform us of the status of the recovery of the $2,808,384 in overpayments that our audit identified,

- identify and recover additional overpayments made on high-dollar outpatient claims paid after calendar year 2003, and

- use the results of this audit in its provider education activities.

In its comments on our draft report, Mutual of Omaha agreed with our recommendations. Mutual of Omaha's comments are included as an appendix.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689. Please refer to report number A-01-05-00514.

Attachment

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

MAY 31 2006

Report Number: A-01-05-00514

Ms. Elizabeth Powers
First Vice President
Medicare Administration, Systems and Development
Mutual of Omaha Insurance Company
P.O. Box 1602
Omaha, Nebraska 68101

Dear Ms. Powers:

Enclosed are two copies of the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG) final report entitled "Excessive Payments for Outpatient Services Processed by Mutual of Omaha." A copy of this report will be forwarded to the action official noted below 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 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-01-05-00514 in all correspondence.

Sincerely yours,

Michael J. Armstrong

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Tom Lenz
Regional Administrator
Centers for Medicare & Medicaid Services, Region VII
U.S. Department of Health and Human Services
Room 235, 610 East 12th Street
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EXCESSIVE PAYMENTS FOR OUTPATIENT SERVICES PROCESSED BY MUTUAL OF OMAHA

Daniel R. Levinson
Inspector General

May 2006
A-01-05-00514

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR part 5.)

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 fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

Since 1985, Mutual of Omaha has been a Medicare Part A intermediary serving about 5,900 Medicare providers nationwide, including more than 900 hospitals. In calendar year 2003, Mutual of Omaha processed 54 outpatient claims that had payments of $50,000 or more.

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that Mutual of Omaha made to providers for outpatient services were appropriate.

SUMMARY OF FINDING

Some of the high-dollar Medicare outpatient payments were not appropriate. During calendar year 2003, Mutual of Omaha made 54 payments of $50,000 or more each for outpatient services. Our analysis indicated that, at the start of our fieldwork in April 2005:

- Nine of the payments were correct.

- Seventeen of the payments were incorrect, and the providers had refunded the $5,466,816 in overpayments.

- Twenty-eight of the payments were incorrect, and the providers had not refunded the $2,808,384 in overpayments.

Contrary to Federal guidance, the providers in all 45 (17 plus 28) instances inappropriately overstated the units of service. Mutual of Omaha made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar year 2003 to detect billing errors related to units of service.

RECOMMENDATIONS

We recommend that Mutual of Omaha:

- inform us of the status of the recovery of the $2,808,384 in overpayments that our audit identified,

- identify and recover additional overpayments made on high-dollar outpatient claims paid after calendar year 2003, and

- use the results of this audit in its provider education activities.

MUTUAL OF OMAHA'S COMMENTS

In its April 25, 2006, comments on our draft report, Mutual of Omaha agreed with our recommendations. Mutual of Omaha's comments are included as an appendix.

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INTRODUCTION

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Fiscal Intermediary Responsibilities

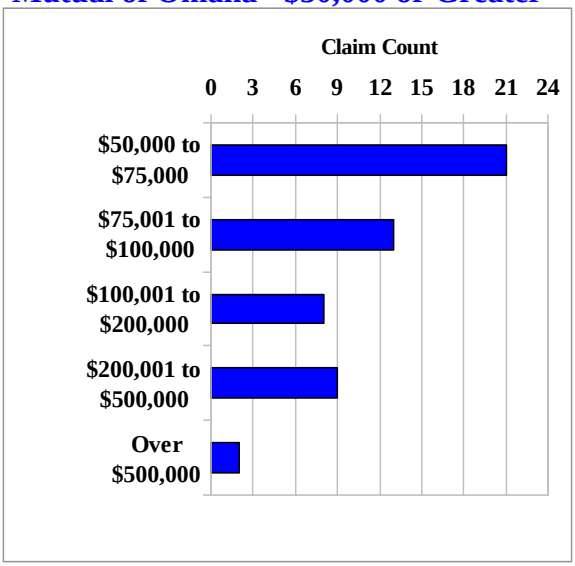
The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for Outpatient Services

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

In calendar year 2003, providers nationwide submitted approximately 132 million outpatient claims. Of these 132 million claims, only 254 claims resulted in payments of $50,000 or more. We considered such claims to be at high risk for overpayment.

Distribution of 54 Claims Processed by Mutual of Omaha - $50,000 or Greater



Mutual of Omaha

Since 1985, Mutual of Omaha has been a Part A intermediary serving about 5,900 Medicare providers nationwide, including more than 900 hospitals. In calendar year 2003, Mutual of Omaha processed more than 14 million Medicare outpatient claims. Only 54 of those claims resulted in payments of $50,000 or more.

The Social Security Act's definition of "provider of services" encompasses hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, renal dialysis facilities, and hospice programs. However, all providers with claims exceeding $50,000 processed by Mutual of Omaha were hospitals; thus, the term "provider" as used in the remainder of this report refers to hospitals.

New Fiscal Intermediary Prepayment Edit

On January 3, 2006, after the end of our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends outpatient claims of $50,000 or more and requires intermediaries to contact providers to determine the legitimacy of the claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that Mutual of Omaha made to providers for outpatient services were appropriate.

Scope

We reviewed the 54 outpatient claims for which Mutual of Omaha paid $50,000 or more each in calendar year 2003. We limited our review of Mutual of Omaha's internal control structure to those controls applicable to the 54 claims because our objective did not require an understanding of all internal controls over claims submission or claims processing. Our review allowed us to establish a reasonable assurance regarding 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 at Mutual of Omaha's office in Omaha, Nebraska, from April through October 2005.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify outpatient claims with Medicare payments of $50,000 or more;
- reviewed available Common Working File claims histories for claims of $50,000 or more to determine whether those claims had been canceled and superseded by a revised claim or whether the payments remained outstanding at the time of our fieldwork;
- contacted the providers with outstanding payments to determine whether the units of service shown on the claims were correct and, if not, why the claims were billed in error and whether the providers agreed that a refund was appropriate; and
- coordinated our review with Mutual of Omaha.

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

FINDING AND RECOMMENDATIONS

Some of the high-dollar Medicare outpatient payments were not appropriate. During calendar year 2003, Mutual of Omaha made 54 payments of $50,000 or more each for outpatient services. Our analysis indicated that, at the start of our fieldwork in April 2005:

- Nine of the payments were correct.

- Seventeen of the payments were incorrect, and the providers had refunded the $5,466,816 in overpayments.

- Twenty-eight of the payments were incorrect, and the providers had not refunded the $2,808,384 in overpayments.

Contrary to Federal guidance, the providers in all 45 (17 plus 28) instances inappropriately overstated the units of service. Mutual of Omaha made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar year 2003 to detect billing errors related to units of service.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). Section 3627.8(C) of the "Medicare Intermediary Manual" states: "The definition of service units is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the 'number of times the service or procedure being reported was performed.' " Furthermore, the "Hospital Manual," section 462, states: "In order to be paid 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 CLAIMS SUBMISSIONS

Of the 54 claims for $50,000 or more, 45 resulted in inappropriate payments. In all 45 instances, the providers billed incorrect and excessive units of service. The following examples illustrate ways in which providers overstated the units of service on individual claims:

- A provider billed for 10,001 units of service for 1 CT scan as the result of a typing error. Mutual of Omaha overpaid approximately $958,000.

- A provider billed for 141 units of service (the number of minutes in the operating room) for 1 shoulder arthroscopy procedure. Mutual of Omaha overpaid approximately $97,000.

- A provider billed for eight units of service (the number of time increments in the operating room) for one cochlear implant procedure. Mutual of Omaha overpaid approximately $67,000.

Our analysis showed that the 45 calendar year 2003 outpatient claims contained overpayments totaling $8,275,200. As of the April 2005 start of our fieldwork, providers had identified and corrected 17 claims with total overpayments of $5,466,816. We gave the remaining 28 claims, which accounted for $2,808,384 of the total overpayments, to both Mutual of Omaha and the respective providers for correction during the course of our fieldwork.

CAUSES OF OVERPAYMENTS

In response to our inquiries, providers attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent incorrect billing of units of service. The providers agreed that overpayments occurred on all 45 claims and that refunds were due.

In addition, during calendar year 2003, Mutual of Omaha did not have prepayment or postpayment controls to identify aberrant payments at the claim level, and the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments to providers. As a result, Medicare relied on providers to notify the intermediaries of excessive payments (as was the case for 17 of the 45 claims) and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments made to providers.

RECOMMENDATIONS

We recommend that Mutual of Omaha:

- inform us of the status of the recovery of the $2,808,384 in overpayments that our audit identified,

- identify and recover additional overpayments made on high-dollar outpatient claims paid after calendar year 2003, and

- use the results of this audit in its provider education activities.

MUTUAL OF OMAHA'S COMMENTS

In its April 25, 2006, comments on our draft report, Mutual of Omaha agreed with all of our recommendations. Mutual of Omaha's comments are included as an appendix.

APPENDIX

Mutual of Omaha Insurance Company
Medicare Area
P.O. Box 1602 • Omaha, NE 68101
1 877 647 6528
mutualmedicare.com
A CMS Contracted Intermediary

April 25, 2006

Michael J. Armstrong
Regional Inspector General
For Audit Services
JFK Federal Building, Room 2425
Boston, MA 02203

Re: CIN A-01-05-00514

Dear Mr. Armstrong:

The Office of Inspector General (OIG) issued a report entitled, "Excessive Payments for Outpatient Services Processed by Mutual of Omaha." In the report, OIG noted their objective was to determine whether high-dollar Medicare payments that Mutual of Omaha made to providers for outpatient services were appropriate.

The OIG recommended that Mutual of Omaha:

- inform the OIG of the status of the recovery of the $2,808,384 in overpayments that their audit identified,
- identify and recover additional overpayments made on high-dollar outpatient claims paid after calendar year 2003, and
- use the results of this audit in its provider education activities

Here is the status of the recovery of the $2,808,384 in overpayments:

- All claims identified were adjusted and the total overpayment recovered was $2,872,922.80.

Here is the status related to identification and recovery of the additional overpayments made on high-dollar outpatient claims:

- A report was produced for all outpatient claims processed from January 2004 through February 2006. A total of 255 claims with the specified criteria were paid during this time frame. These claims were reviewed to determine if they were paid appropriately. Of the 255 claims, 52 were not paid appropriately and will be adjusted to facilitate the overpayment recovery process. We will provide the final results once the adjustment process is completed.

Some provider education activities have been completed and additional educational activities will also continue in the foreseeable future.

- Effective January 3, 2006, Reason Code 37551 was implemented in the Fiscal Intermediary Standard System (FISS), which suspends claims with a payment of $50,000 or more. After the claims are suspended, they are reviewed by Mutual of Omaha staff and may be returned to the billing providers for review of units and charges. If needed the providers are to make corrections before resubmitting the claims. When CMS issued Change Request 3925 regarding this new edit in FISS, they required that a listserv notification and Newsletter article to be issued to our providers about this change. We issued an Electronic Mail List message on August 10, 2005, and published the Newsletter article on September 1, 2005.

- Enclosed is a copy of a provider-training module titled OPPS Update 2006. On slide 15 of this module, we explain that we are reviewing outpatient claims when the amount would be $50,000 or greater. This module is presented at workshops with the affected provider community.

If you have any questions, please contact me at 402-351-2570 or Michelle Routt 402-351-8293.

Sincerely,

Elizabeth Powers
First Vice President
Medicare Administration, Systems and Development

cc: John Phelps, KCRO