Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

Duplicate Medicare Payments by Individual Carriers

JUNE 2001
OEI-03-00-00091

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OEI's Philadelphia Regional Office prepared this report under the direction of Robert A. Vito, Regional Inspector General, and Linda M. Ragone, Deputy Regional Inspector General. Principal OEI staff included:

REGION

Robert Katz, *Project Leader*
Erika Q. Lang, *Program Analyst*

HEADQUARTERS

Tricia Davis, *Program Specialist*

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EXECUTIVE SUMMARY

PURPOSE

To determine if individual carriers made duplicate payments for the same Medicare Part B services.

BACKGROUND

The Health Care Financing Administration (HCFA) contracts with private health insurance companies called carriers to process Medicare Part B claims. After furnishing a service, providers submit a claim for reimbursement to the carrier with jurisdiction over the service. The carrier initially processes the claim, then sends it to one of nine Common Working File host sites for approval. Both the carriers and the Common Working File host sites review incoming claims for possible duplication using certain criteria, such as the dates of service, provider identification number, procedure code, and place of service. If a claim is found to be identical to another based on these criteria, it should be denied.

For this inspection, we reviewed potential duplicate services from HCFA's 5 percent National Claims History file for 1998. Our analysis focused on 15 procedure codes that should never or rarely be billed more than once a day, and that were the subject of a previous Office of Inspector General study about duplicate payments made by more than one carrier. In this study, we examined potential duplicate services which were submitted for reimbursement to and paid by the same carrier. We also expanded our review to include all other procedure codes.

FINDINGS

Medicare carriers made potential duplicate payments in 1998

For the 15 procedure codes that should never or rarely be billed more than once per day, individual carriers made potential duplicate payments involving 3,152 services in 1998. Questionable allowances for the 15 codes totaled an estimated $2.25 million. Individual carriers made an estimated $2.2 million in potential duplicate payments for an additional 55 evaluation and management codes that should never or rarely be billed more than once per day. We also estimated that Medicare made $89 million in potential duplicate payments for 2,000 other procedure codes. However, for this latter group, it is possible that some of the duplicate services for these codes were appropriately billed, as we did not investigate their validity.

One carrier paid for more than one-third of the potential duplicate services

One carrier accounted for 37 percent of duplicate services for the first 15 procedure codes we analyzed, more than four times the number for the next highest carrier. Almost all carriers in 1998 made duplicate payments for the 15 procedure codes.

Carrier and Common Working File edits did not prevent potential duplicate payments

Carrier edits should have identified and denied 40 percent of the duplicate services for the 15 procedure codes. Eight percent of the duplicate services should have been denied based on Common Working File edits.

RECOMMENDATIONS

This inspection, combined with our previous inspection report (OEI-03-00-00090) on duplicate payments by more than one carrier, establishes that some claims for potential duplicate services are not being detected by Medicare carriers and the program's Common Working File systems.

To address the vulnerabilities identified in this report, we recommend that HCFA:

< **investigate Medicare's claims processing systems to determine why potential duplicate services were not detected. Payments should be recovered for those services determined to be inappropriate.**

< **implement corrective edits or related measures within carrier and Common Working File claims processing systems to detect and prevent payments for duplicate services billed to the same carrier. If these measures are determined not to be cost effective, then conduct additional post-payment reviews, particularly for those carriers in which high numbers of duplicate payments were detected.**

We have forwarded claims information to HCFA so they may take appropriate action regarding the possible duplicate payments cited in this report.

AGENCY COMMENTS

The HCFA concurred with our recommendations. In response to our first recommendation, the HCFA stated that they will continue to assess existing duplicate payment edits in the Common Working File as well as the Medicare Part B standard claims processing systems. The HCFA also plans to reexamine existing edits involved with preventing payments for duplicate services in individual carrier systems. Part of this examination will include an assessment of those carriers in which a high number of

duplicate payments were detected. Upon release of this report, HCFA will proceed with recovery actions involving the duplicate payments identified. In response to our second recommendation, the HCFA has established a workgroup to analyze potential vulnerabilities in existing systems edits. Based upon the workgroup's findings, HCFA will determine appropriate corrective actions to reduce duplicate payments within the same carrier. Further, HCFA will consider tasking a program safeguard contractor to conduct analysis, identify past instances of duplicate billings within the same carrier, and initiate any overpayment recoveries.

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INTRODUCTION

PURPOSE

To determine if individual carriers made duplicate payments for the same Medicare Part B services.

BACKGROUND

During the course of a previous inspection entitled "Medicare Payments for the Same Service by More Than One Carrier," (OEI-03-00-00090), we found evidence that not only multiple carriers, but the same carriers, were paying for potential duplicate services. Accordingly, we decided to conduct a separate review related to this issue. This inspection report is a product of that review.

Processing Part B Claims

The Health Care Financing Administration (HCFA), which administers the Medicare program, contracts with private health insurance companies called carriers to process most Part B claims for payment. Claims under Medicare Part B include medical and surgical services by physicians, ambulance services, outpatient hospital services, and laboratory services.

After Part B services are furnished to a Medicare beneficiary, the provider submits a claim for reimbursement to the appropriate Medicare carrier. The carrier enters the claim into its processing system, calculates the payment amount, and conducts consistency and utilization checks using computerized edits. The carrier then sends the claim to one of nine host sites of the Common Working File system. The HCFA established the Common Working File system in 1991 to improve the accuracy of claims processing. The host sites maintain beneficiary claims history and entitlement information. Each beneficiary is assigned to only one host site. At the host site, the claim is screened for consistency, entitlement, and duplication of previously processed claims. Within 24 hours of receiving a claim, the host site makes one of three payment determinations: (1) pay the claim, (2) reject the claim, or (3) hold the claim to obtain missing information.

Detecting Duplicate Payments

As part of Medicare's guidelines to detect and prevent inappropriate payments, both the carriers and the Common Working File system conduct checks on claims to detect duplicate payments. According to procedures described in the Medicare Carriers Manual

regarding the control of potential duplicate payments, as well as information obtained from HCFA, carriers automatically disallow claims for duplicate services that match on the following fields: start and end dates of service, the beneficiary's health insurance claim number, provider identification number, type of service, procedure code, place of service, and submitted charge. As a further check for duplicate services, service dates are matched with one or more of the following variables: provider identification number, type of service, and procedure code. If these items match, the claim is held for review and duplicate payments are denied. Line items within claims are also compared for duplicate entries. The Common Working File host sites check for duplicate claims by comparing the carrier number, the claim's document control number, and service dates on the Common Working File history record. If these fields are identical on two claims, one claim is denied.

METHODOLOGY

For our previous inspection "Medicare Payments for the Same Service by More Than Once Carrier" (OEI-03-00-00090), we examined 1998 Part B paid services for a 5 percent sample of Medicare beneficiaries in HCFA's National Claims History file. We used six criteria to determine if two services appeared to be duplicate: the beneficiary's health insurance claim number; the unique physician identification number of the provider performing the service; the start date of service; HCFA's Common Procedure Coding System code describing the service; and the two modifiers that can further describe the service. If the six criteria for two services were identical, we considered those services to be potential duplicates. We then identified a universe of services that had been billed to more than one carrier from this pool of potentially duplicate services. The medical staff of a carrier assisted us in selecting 15 codes that either should only be billed once per day by a single provider or that should rarely be billed more than once per day. A description of the 15 procedure codes is provided in Appendix A. From these 15 codes, we selected a random sample of 242 potential duplicate services paid by more than one carrier. We contacted the 86 providers who performed the sample services and requested medical documentation to justify the billings. None of the documentation received justified billings to more than one carrier.

Data Collection and Analysis

For the current inspection, we focused our analysis on services for the 15 procedure codes used in the previous inspection, since these codes should never or rarely be billed more than once a day. From the 1998 National Claims History 5 percent file, we identified all services for the 15 codes using the same six criteria described above, but that were paid by the same carrier. Since the documentation obtained in the earlier study did not justify more than one payment for any of the duplicate services, we did not ask providers to send medical documentation for this review.

We later expanded our review to include additional evaluation and management codes. According to a carrier's medical review staff, 55 of 58 evaluation and management codes identified as having potential duplicate services should never or rarely be billed more than once a day. These 55 codes exclude evaluation and management services contained in the 15 procedure codes cited above. We identified all potential duplicate services paid by the same carrier for the 55 codes using the same six criteria defined earlier. We did not contact the providers of these services for documentation or further clarification of their billings. A description of the 55 evaluation and management codes is provided in Appendix B.

In order to illustrate the possible scope of potential duplicate services paid by individual Part B carriers, we analyzed the duplicate services for all procedure codes, excluding the 70 codes mentioned above. Using the six criteria referred to above, we identified potentially duplicate services for approximately 2,000 procedure codes. For these codes, we neither asked providers for supporting medical documentation nor asked a carrier's medical staff to review these services.

Based on the results of the previous inspection, we presumed that, within a set of duplicate services, one service was appropriate and the related duplicate service(s) was not. For monetary calculations, we determined questionable payments from the service(s) with the lowest allowed amounts.

For the potential duplicate services, we identified the carriers that were responsible for making the payments. We also applied the edit criteria used by carriers and the Common Working File system to determine if the potential duplicate services we identified should have been detected by Medicare's claims processing systems.

With respect to the 15 original procedure codes and 55 evaluation and management codes referred to above, it is unlikely that duplicate services for many of these codes were appropriately billed, in view of the results of our previous inspection and the advice of a carrier's medical review staff which indicated these services should never or rarely be billed more than once a day. However, we are less certain about the potentially duplicate services involving the other 2,000 codes, as we neither analyzed these codes in the earlier report nor checked their appropriateness with a carrier's medical review staff. In the final analysis, each duplicate service will have to be investigated to determine its validity.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Medicare carriers made potential duplicate payments in 1998

Medicare allowed an estimated $2.25 million in potential duplicate payments for 15 codes

In our sample, individual carriers made duplicate payments involving 3,152 services for 15 procedure codes. These codes should never or rarely be billed more than once per day. Using the lowest allowed amounts for each duplicate service, questionable allowances equaled approximately $112,000. Based on this, we estimate that Medicare made a total of $2.25 million in duplicate payments for the 15 codes in 1998. See Appendix C for estimates and confidence intervals.

As shown in Table 1, questionable allowances for each code ranged from approximately $800 for spinal canal magnetic resonance imaging (72158) to more than $28,000 for subsequent hospital care per day (99232).

Table 1. Questionable Allowances and Services Involving Duplication for 15 Codes

Procedure Code	Amount of Questionable Allowances	Number of Services Involving Duplication
99232	$28,119.80	719
99213	$26,849.81	1,439
66984	$14,304.78	77
90921	$7,893.87	75
99254	$5,735.81	95
99223	$5,646.48	83
70553	$4,956.45	38
90862	$3,516.41	179
99238	$3,120.49	103
90801	$2,971.26	52
99204	$2,546.38	62
99244	$2,508.24	54
11721	$2,319.00	124
90816	$1,193.52	50
72158	$818.88	2
TOTAL	**$112,501.18**	**3,152**

Source: 1998 National Claims History 5 percent file

The duplicate services for the 15 procedure codes consisted of services that, according to claims data in the 5 percent claims file, were billed to and paid by the same carrier at least twice. We found examples in which a carrier paid for the same service more than two times. For example, we found 22 different instances in which a carrier paid for the same service three times. One carrier paid a physician for six subsequent hospital visits

on the same day for the same beneficiary. Another carrier paid a provider ten times for the debridement of six or more nails for one beneficiary on the same day.

Medicare allowed an estimated $2.2 million in potential duplicate payments for 55 evaluation and management codes

We reviewed an additional 58 evaluation and management codes that had potential duplicate services in 1998. Of these 58 codes, a carrier's medical staff stated that 55 should never or rarely be billed more than once per day. We estimate that Medicare made an additional $2.2 million in duplicate payments for these 55 evaluation and management codes in 1998. The 55 procedure codes include services such as subsequent nursing facility care per day (99312), critical care evaluation and management--first hour (99291), and follow-up inpatient consultation for an established patient (99262).

Potential duplicate payments were found for other procedure codes

In order to illustrate the possible extent of potential duplicate services paid by individual Part B carriers, we also identified duplicate services for all procedure codes besides the 70 codes mentioned previously. We estimate that Medicare made $89 million in potential duplicate payments for these procedure codes.

The potential duplicate payments comprised nearly 2,000 procedure codes. The types of services represented by the codes that occurred most frequently included laboratory and pathology tests, vascular diagnostic tests, physical medicine and rehabilitative services, and ambulance services. It is possible that some of the duplicate services that we identified may have been appropriately billed, as we did not investigate their validity. However, the definitions for certain services suggest a provider would never or rarely furnish a beneficiary with more than one of these services on the same day. For example, procedure code 90925 is defined as end stage renal disease related services per day.

One carrier paid for more than one-third of the potential duplicate services

One carrier accounted for 37 percent of the duplicate services for the 15 procedure codes in 1998. However, this carrier accounted for only 4 percent of all Part B services in 1998. This carrier paid for 1,180 of the 3,152 duplicate services, more than four times the number for the next highest carrier (253). Almost all carriers (92 percent) made payments for duplicate services involving the 15 procedure codes in 1998. Seventeen carriers paid for more than 50 potentially duplicate services for the 15 procedure codes, while 5 carriers made only 2 duplicate payments. Table 2 shows the five carriers with the highest number of duplicate services involving the 15 procedure codes.

Table 2. Number of Services Involving Duplication for Top Five Carriers

Carrier	Number of Services Involving Duplication for 15 Procedure Codes	Percent of Total Duplicate Services
1	1,180	37%
2	253	8%
3	129	4%
4	128	4%
5	97	3%

Source: 1998 National Claims History 5 percent file

The carrier accounting for 37 percent of the duplicate services for the 15 procedure codes in 1998 also had the highest number of potential duplicate services involving the 55 additional evaluation and management codes reviewed. This carrier paid for one-third of the services for these evaluation and management codes.

Carrier and Common Working File edits did not prevent potential duplicate payments

Carrier edits

Forty percent of the duplicate services for the 15 procedure codes should have been disallowed, based on carrier edits. At the carrier level, claims for duplicate services that match on the following eight fields are disallowed: start and end dates of service, beneficiary's health insurance claim number, provider identification number, type of service, procedure code, place of service, and submitted charge. In examining these eight fields for the selected duplicate services, we found that they were identical for 40 percent of the duplicate services. According to the Medicare Carriers Manual, these duplicate services should have been disallowed without clerical intervention.

Of the remaining duplicate services for which the eight fields were not identical, 79 percent had non-matching provider identification numbers. While providers have only one unique physician identification number, they may have more than one provider identification number, which is a billing number assigned by carriers to designate separate practice locations or accounting designations. Carrier computer edits cannot detect duplicate services if the provider identification numbers are different. Therefore, the non-matching provider identification numbers may have allowed these duplicate payments to go undetected.

Common Working File edits

Eight percent of the duplicate services for the 15 procedure codes should have been denied, based on Common Working File edits. At the host sites, if four fields — the carrier number, the claim's document control number, and the start and end dates of

service — on two claims are identical, one claim should be denied. In examining these four fields for our selected duplicate services, we found that they were identical for 8 percent of the duplicate services.

Of the remaining duplicate services for which the four fields were not identical, almost all had non-matching document control numbers. A unique document control number is assigned by the carrier to each claim that a provider submits. The Common Working File edit is designed to detect duplicate services based, in part, on comparing the document control numbers. The high percentage of duplicate services with different document control numbers may explain how they evaded detection at the Common Working File level.

RECOMMENDATIONS

This inspection, combined with our previous inspection report (OEI-03-00-00090) on duplicate payments by more than one carrier, establishes that some claims for potential duplicate services are not being detected by Medicare carriers and the program's Common Working File systems.

To address the vulnerabilities identified in this report, we recommend that HCFA:

< **investigate Medicare's claims processing systems to determine why potential duplicate services were not detected. Payments should be recovered for those services determined to be inappropriate.**

< **implement corrective edits or related measures within carrier and Common Working File claims processing systems to detect and prevent payments for duplicate services billed to the same carrier. If these measures are determined not to be cost effective, then conduct additional post-payment reviews, particularly for those carriers in which high numbers of duplicate payments were detected.**

We have forwarded claims information to HCFA so they may take appropriate action regarding the possible duplicate payments cited in this report.

AGENCY COMMENTS

The HCFA concurred with our recommendations. In response to our first recommendation, the HCFA stated that they will continue to assess existing duplicate payment edits in the Common Working File as well as the Medicare Part B standard claims processing systems. The HCFA also plans to reexamine existing edits involved with preventing payments for duplicate services in individual carrier systems. Part of this examination will include an assessment of those carriers in which a high number of duplicate payments were detected. Upon release of this report, HCFA will proceed with recovery actions involving the duplicate payments identified. In response to our second recommendation, the HCFA has established a workgroup to analyze potential vulnerabilities in existing systems edits. Based upon the workgroup's findings, HCFA will determine appropriate corrective actions to reduce duplicate payments within the same carrier. Further, HCFA will consider tasking a program safeguard contractor to conduct analysis, identify past instances of duplicate billings within the same carrier, and initiate any overpayment recoveries.

APPENDIX A

Description of 15 Procedure Codes

The following is a list of the 15 procedure codes selected for our primary analysis, as well as a description of the codes.

Procedure Code	Description of Code*
11721	Debridement of six or more nails by any method
66984	Extracapsular cataract removal with insertion of intraocular lens prostheses
70553	Brain magnetic resonance imaging without contrast material
72158	Magnetic resonance imaging, spinal canal and contents, without contrast material, lumbar
90801	Psychiatric diagnostic interview examination
90816	Individual psychotherapy, 20-30 minutes, inpatient setting
90862	Pharmacologic management
90921	End stage renal disease related services per full month, for patients 20 years of age or older
99204	Office or other outpatient visit for evaluation and management of new patient
99213	Office or other outpatient visit for evaluation and management of established patient
99223	Initial hospital care, per day, for evaluation and management of patient
99232	Subsequent hospital care, per day, for evaluation and management of patient
99238	Hospital discharge day management, 30 minutes or less
99244	Office consultation for new or established patient
99254	Initial inpatient consultation for new or established patient

*** Source:** ***1998 Physician's Current Procedural Terminology***

APPENDIX B

Description of 55 Evaluation and Management Codes

The following is a list of the 55 evaluation and management codes selected for analysis, as well as a description of the codes.

Procedure Code	Description of Code*
99201	Office or other outpatient visit, new patient
99202	Office or other outpatient visit, new patient
99203	Office or other outpatient visit, new patient
99205	Office or other outpatient visit, new patient
99211	Office or other outpatient visit, established patient
99212	Office or other outpatient visit, established patient
99214	Office or other outpatient visit, established patient
99215	Office or other outpatient visit, established patient
99217	Observation care discharge day management
99219	Initial observation care, per day
99220	Initial observation care, per day
99221	Initial hospital care, per day
99222	Initial hospital care, per day
99231	Subsequent hospital care, per day
99233	Subsequent hospital care, per day
99235	Observation or inpatient hospital care
99236	Observation or inpatient hospital care
99239	Hospital discharge day management, more than 30 minutes
99241	Office consultation, new or established patient
99242	Office consultation, new or established patient
99243	Office consultation, new or established patient
99245	Office consultation, new or established patient
99251	Initial inpatient consultation, new or established patient
99252	Initial inpatient consultation, new or established patient
99253	Initial inpatient consultation, new or established patient
99255	Initial inpatient consultation, new or established patient

Description of 55 Evaluation and Management Codes (cont.)

Procedure Code	Description of Code*
99261	Follow-up inpatient consultation, established patient
99262	Follow-up inpatient consultation, established patient
99263	Follow-up inpatient consultation, established patient
99274	Confirmatory consultation, new or established patient
99275	Confirmatory consultation, new or established patient
99281	Emergency department visit
99282	Emergency department visit
99283	Emergency department visit
99284	Emergency department visit
99285	Emergency department visit
99291	Critical care evaluation and management, first hour
99301	Nursing facility assessment, new or established patient
99302	Nursing facility assessment, new or established patient
99303	Nursing facility assessment, new or established patient
99311	Subsequent nursing facility care, per day
99312	Subsequent nursing facility care, per day
99313	Subsequent nursing facility care, per day
99315	Nursing facility discharge day management, 30 minutes or less
99332	Rest home visit, established patient
99341	Home visit, new patient
99342	Home visit, new patient
99343	Home visit, new patient
99347	Home visit, established patient
99348	Home visit, established patient
99349	Home visit, established patient
99350	Home visit, established patient
99354	Prolonged physician service, office setting, first hour
99356	Prolonged physician service, inpatient setting, first hour
99375	Physician care plan oversight services, 30 minutes or more

*** Source:** ***1998 Physician's Current Procedural Terminology***

APPENDIX C

Estimates and Confidence Intervals

The tables below contain statistical estimates presented in the findings section of this report. The point estimates and corresponding 95 percent confidence intervals, based on a 5 percent sample of HCFA's 1998 National Claims History file, were computed using standard statistical formulas for a simple random sample.

	Point Estimate	95% Confidence Interval
Questionable Medicare Allowances for 15 Original Codes	$2,250,024	$2,067,454 - $2,432,593

	Point Estimate	95% Confidence Interval
Questionable Medicare Allowances for 55 Evaluation and Management Codes	$2,205,158	$2,091,705 - $2,318,610

	Point Estimate	95% Confidence Interval
Questionable Medicare Allowances for All Services Except Ones Involving 15 Original Codes and 55 Evaluation and Management Codes (Represents 1,906 Codes)	$89,658,205	$87,611,633 - $91,704,777

APPENDIX D

Health Care Financing Administration Comments

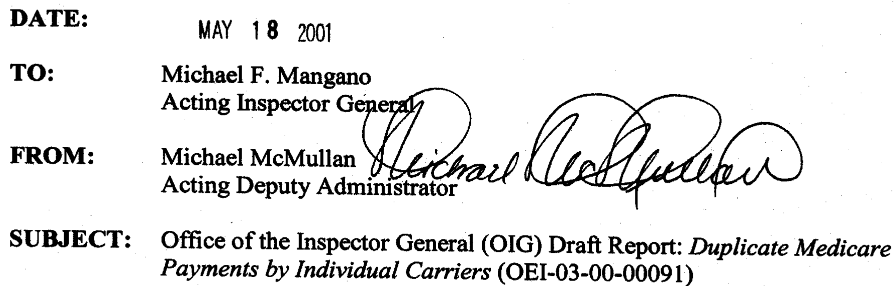
DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: MAY 18 2001

TO: Michael F. Mangano
Acting Inspector General



FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: *Duplicate Medicare Payments by Individual Carriers* (OEI-03-00-00091)

Thank you for the opportunity to comment on the above-referenced OIG draft report.

The Health Care Financing Administration (HCFA) has been aggressive in its efforts to make sure that we pay Medicare claims correctly. Medicare has reduced its improper payment rate sharply from 14 percent 4 years ago to 6.8 percent last year, and HCFA is committed to achieving further reductions in the future.

As required by the Medicare statute, HCFA contracts with private insurance companies to handle Medicare claims processing. These contractors use one of several electronic claims processing systems, which must be approved by HCFA. Today, providers submit nearly 90 percent of claims electronically, and the vast majority of those claims go through the system and are paid without manual intervention. Given that Medicare pays nearly 1 billion claims from more than 1 million physicians, hospitals, and other health care providers, reliance on electronic processing is inevitable.

In order to minimize payment errors without unduly impeding claims processing, HCFA may require its contractors to install edits in their claims processing software to flag claims that should not be paid, at least without further review. In some cases, these edits are designed to target questionable billing patterns that have been identified through post-payment review or audits. For example, if a carrier discovers an aberrant billing problem with regard to a particular procedure code, the carrier is required to develop a local medical review policy limiting payment for that procedure to specified diagnoses.

Other types of edits are more system-wide. For example, HCFA has instituted a Correct Coding Initiative to identify two types of suspect claims:

(1) claims by the same provider for the same patient for the same date of service for a procedure that includes several component procedures, and for one or more of the components (comprehensive/component code edits); and

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(2) claims for two procedures which logically would not be performed on the same patient on the same day (mutually exclusive code edits).

The duplicate payment edits, discussed in this report, are another type of system-wide edit. These edits are designed to deny claims for services that appear to be duplicates; that is, the data supplied by the provider with regard to the beneficiary; the date, type, and place of service; and the submitted charge are identical on two separate claims. These edits are also capable of comparing line items within claims for multiple services.

When discussing payments, it is important to recognize that there may be situations in which the same provider renders the same service to the same beneficiary on the same day. In such a case, assuming both services are medically necessary, the provider should be paid for both services.

Based on OIG findings, when the report is issued in final HCFA will direct the Medicare carriers to initiate and complete recovery action.

With regard to the specific OIG recommendations, our comments are as follows:

OIG Recommendation
HCFA should investigate Medicare's claims processing systems to determine why potential duplicate services were not detected. Payments should be recovered for those services determined to be inappropriate.

HCFA Response
We concur. HCFA will continue to assess the existing duplicate payment edits in the Common Working File (CWF) and in the Medicare Part B standard claims processing systems. We will also examine the existing edits aimed at preventing payments for duplicate services in the individual Medicare carrier systems. Our analysis will include an assessment of those carriers in which a high number of duplicate payments were detected.

HCFA will direct the Medicare carriers to recover the overpayments for services determined to be inappropriate. When the final report is issued, OIG will furnish the data necessary (provider numbers, claims information, health insurance claim numbers, etc.) for the Medicare contractors to initiate and complete recovery action. At that time, we will forward the final report and information needed by the Medicare contractors to effectuate recovery of the overpayments to the regional offices for appropriate action. We will also identify a HCFA person for OIG to contact if any questions arise.

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OIG Recommendation
HCFA should implement corrective edits or related measures within carrier and CWF claims processing systems to detect and prevent payments for duplicate services billed to the same carrier. If these measures are determined not to be cost effective, then conduct additional post-payment reviews, particularly for those carriers in which high numbers of duplicate payments were detected.

HCFA Response
We concur. A workgroup has been established to analyze potential vulnerabilities in the existing systems edits. Based upon the findings, we will determine appropriate corrective actions to reduce vulnerabilities to duplicate payments within the same carrier. We will consider tasking a program safeguard contractor to conduct analysis, identify past instances of duplicate billing within the same carrier, and notify the individual carriers of the need to recover any overpayments.