DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

March 27, 2009

Report Number: A-06-08-00067

Mr. Guy Ringle
Senior Vice President, Medicare
WPS Insurance Company
1707 West Broadway
Madison, Wisconsin 53707-7927

Dear Mr. Ringle:

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 Outpatient Claims Processed by TriSpan Health Services for the Period January 1 Through December 31, 2004." 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 Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. 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 at (214) 767-8414, or contact Trish Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00067 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. 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
rokcmora@cms.hhs.gov

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENT FOR MEDICARE OUTPATIENT CLAIMS PROCESSED BY TRISPAN HEALTH SERVICES FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 2004

Daniel R. Levinson
Inspector General

March 2009
A-06-08-00067

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries used the Fiscal Intermediary Standard System and CMS's Common Working File to process payments for claims. The Common Working File can detect certain improper payments during prepayment validation.

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.

TriSpan Health Services (TriSpan) is a Medicare fiscal intermediary serving more than 1,300 Medicare providers in Mississippi, Louisiana, and Missouri. For calendar year (CY) 2004, TriSpan processed approximately 3.7 million outpatient payments, 20 of which resulted in payments of $50,000 or more (high-dollar payments). Sixteen of the payments were to providers in Missouri.

On September 5, 2007, CMS awarded Wisconsin Physicians Service Insurance Corporation (WPS) the contract for the combined administration of Part A and Part B Medicare fee-for-service payments in Jurisdiction 5, which includes the states of Iowa, Kansas, Missouri, and Nebraska. Because WPS is now responsible for Missouri payments, this report includes the 16 CY 2004 payments to Missouri providers; we reported the remaining 4 payments to TriSpan in a separate report.

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 16 high-dollar payments that TriSpan made to providers, 15 were not appropriate. TriSpan overpaid two providers a total of $766,929 because the providers incorrectly billed excessive units of service and because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2004 to detect billing errors related to units of service. We did not review the remaining payment because the provider had withdrawn from the Medicare program and we were not able to obtain supporting documentation.

RECOMMENDATIONS

We recommend that WPS:

- ensure that the 15 overpayments, totaling $766,929, have been recovered and
- use the results of this audit in its provider education activities.

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS

In its comments on our draft report, WPS agreed with our findings and recommendations. The full text of WPS's comments is included as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

To process providers' outpatient payments, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments when processing payments for prepayment validation.

In calendar year (CY) 2004, fiscal intermediaries processed and made more than 136 million outpatient payments, 588 of which resulted in payments of $50,000 or more (high-dollar payments). We consider such payments to be at high risk for overpayment.

Claims for Outpatient Services

Providers generate the claims for outpatient services provided to Medicare beneficiaries. 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.

TriSpan Health Services

TriSpan Health Services (TriSpan) is a Medicare fiscal intermediary that served more than 1,300 Medicare providers in Mississippi, Louisiana, and Missouri in CY 2004. For claims in CY 2004, TriSpan processed approximately 3.7 million outpatient payments, 20 of which resulted in high-dollar outpatient payments. Sixteen of the payments were to providers in Missouri.

Wisconsin Physicians Service Insurance Corporation

On September 5, 2007, CMS awarded Wisconsin Physicians Service Insurance Corporation (WPS) the contract for the combined administration of Part A and Part B Medicare fee-for-service payments in Jurisdiction 5, which includes the states of Iowa, Kansas, Missouri, and Nebraska. Because WPS is now responsible for Missouri payments, this report includes the 16 payments to Missouri providers; we reported the remaining 4 payments to TriSpan in a separate report.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 16 high-dollar payments for outpatient claims that TriSpan processed for Missouri providers. We limited our review of TriSpan's internal controls to those applicable to the 16 payments because our objective did not require an understanding of all internal controls over the submission and processing of payments. Our review allowed us to establish a 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 audit work from May 2008 through January 2009.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare outpatient claims with high-dollar payments;
- reviewed available Common Working File payment histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our audit;
- contacted the providers that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect and whether the providers agreed that refunds were appropriate; and
- coordinated our review with WPS.

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.

FINDINGS AND RECOMMENDATIONS

Of the 16 high-dollar payments that TriSpan made to providers, 15 were not appropriate. TriSpan overpaid two providers a total of $766,929 because the providers incorrectly billed excessive units of service and because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2004 to detect billing errors related to units of service. We did not review the remaining payment because the provider had withdrawn from the Medicare program and we were not able to obtain supporting documentation.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P. L. No. 99-509, requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of this manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" requires the fiscal intermediary to maintain adequate internal controls over Medicare automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Two providers billed for an incorrect number of units on 15 high-dollar payments.

- One provider billed procedure code C9205 for an incorrect number of units on 14 payments. The provider stated that the overpayments occurred because its former billing system contained an incorrect procedure code conversion factor, which converts administered units to billable units. As a result, TriSpan paid the provider $854,712 when it should have paid $125,580, an overpayment of $729,132.

- One provider billed procedure code J9310 for an incorrect number of units on one payment. The provider attributed the incorrect number of units to a conversion factor error in its computer system. As a result, TriSpan paid the provider $52,091 when it should have paid $14,294, an overpayment of $37,797.

CAUSES OF OVERPAYMENTS

The providers agreed that overpayments had occurred and that refunds were due or had already been made. The providers attributed the incorrect payments to their software edit programs, which did not detect and prevent incorrect billing of units of service.

In addition, during CY 2004, TriSpan did not have prepayment or postpayment controls to identify overpayments at the payment level, and the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments. In effect, CMS relied on

providers to notify the intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[1]

FISCAL INTERMEDIARY PREPAYMENT EDIT

On January 3, 2006, after 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 high-dollar outpatient payments and requires intermediaries to determine the legitimacy of the payments.

RECOMMENDATIONS

We recommend that WPS:

- ensure that the 15 identified overpayments, totaling $766,929, have been recovered and
- use the results of this audit in its provider education activities.

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS

In its comments on our draft report, WPS agreed with our findings and recommendations. In response to the first recommendation, WPS said that it intends to recoup the overpayment amounts for the 15 claims while abiding by the 4-year reopening guidelines. In response to the second recommendation, WPS said that it will use the results of this audit, when applicable, in its future educational activities.

The full text of WPS's comments is included as the Appendix.

OTHER MATTERS

While researching the payments in our review, both providers identified additional payments with units-of-service errors that were not within the scope of our audit because the payments either were not high-dollar payments or had 2005 dates of service. One provider billed eight additional claims with an incorrect number of units for procedure code C9205. As a result, TriSpan paid $260,597 when it should have paid $31,757, an overpayment of $228,840. The other provider billed two additional claims with an incorrect number of units for procedure code J9310. As a result, TriSpan paid $49,670 when it should have paid $16,710, an overpayment of $32,960. WPS has processed the corrected payments.

[1]The fiscal intermediary sends an "Explanation of Medicare Benefits" notice to the beneficiary after the hospital files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

March 16, 2009

Gordon L. Sato
Regional Inspector General for Audit Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Re: OIG Blue Book Audit A-06-08-00067 – February 2009

Dear Mr. Sato:

This letter is in response to the Draft OIG Blue Book titled "Review of High-Dollar Payments for Medicare Outpatient Claims Processed by TriSpan Health Services for the Period January 1 through December 31, 2004." In your letter, you requested that comments be provided on each of the recommendations.

WPS assumed responsibility for Missouri and associated TriSpan's processing activity in 2008. The OIG reviewed 16 high-dollar outpatient claims, of which 15 were not appropriate. The results of their review indicated that these 15 payments included overpayments totaling $766,929.

OIG Recommendations:

- *Ensure that the 15 overpayments, totaling $766,929, have been recovered and,*
- *Use the results of this audit in its provider education activities.*

WPS intends to recoup the overpaid amounts for the 15 claims. We will do this by collecting the overpayments, including abiding by the four-year reopening guidelines. WPS staff will use the results of this audit, where applicable, in our future educational activities.

WPS looks forward to working with you in the completion of this OIG Audit of high-dollar payments by TriSpan. If you have any questions, or need any more information please contact me at 402-351-6915.

Sincerely,

Mark DeFoil
Director, Contract Coordination

cc: Patricia Wheeler, OIG
Nitza Correa, CMS
Suzanne Johnson, CMS

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