DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

MAR 1 0 2009

Report Number: A-04-08-00045

Mr. Brian Setzer, Vice President of Operations
CIGNA Government Services
Two Vantage Way
Nashville, Tennessee 37228

Dear Mr. Setzer:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Part B Claims Processed by CIGNA Government Services Carrier No. 05440 for the Period January 1, 2004, Through December 31, 2006." We will forward a copy of this report to the HHS action official on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Eric Bowen, Audit Manager, at (404) 562-7789 or through e-mail at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-08-00045 in all correspondence.

Sincerely,

Peter J. Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

**Direct Reply to HHS Action Official**:

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF INSPECTOR GENERAL**

# REVIEW OF HIGH-DOLLAR PART B CLAIMS PROCESSED BY CIGNA GOVERNMENT SERVICES CARRIER NO. 05440 FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2006

Daniel R. Levinson
Inspector General
March 2009
A-04-08-00045

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http://oig.hhs.gov

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**
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Pursuant to the principles of the Freedom of Information Act , 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

## OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

## EXECUTIVE SUMMARY

### BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers). CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed.

Carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File to process Part B claims. These systems can detect certain improper payments during prepayment validation.

CIGNA Government Services (CGS) has been a contractor for CMS since its inception in 1966. CGS is responsible for Part B claims processing in Idaho, Tennessee, and North Carolina under contract with CMS. During calendar years (CY) 2004–2006, CGS carriers processed approximately 144 million Part B claims. CGS Part B carrier No. 05440 (the contractor) is the Medicare Part B carrier for about 23,900 providers in Tennessee. During CYs 2004–2006, the contractor processed more than 58 million Part B claims, 1,131 of which resulted in payments of $10,000 or more (high-dollar payments). These high-dollar claims totaled $27,229,897.

### OBJECTIVE

Our objective was to determine whether CGS high-dollar payments to Tennessee Part B providers were appropriate.

### SUMMARY OF FINDINGS

The contractor appropriately made 1,111 of the 1,131 high-dollar payments to Tennessee providers. However, we identified 20 overpayments totaling $204,579. Generally, the contractor made the overpayments because the providers incorrectly billed excessive units of service. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004–2006 to detect and prevent payments for these types of erroneous claims.

### RECOMMENDATION

We recommend that the contractor recover the $204,579 in identified overpayments.

### AUDITEE COMMENTS

In written comments on the draft report, CIGNA Government Services stated that it had adjusted these 20 claims and was pursuing the associated overpayments. CGS's comments are included in their entirety as the Appendix.

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# INTRODUCTION

## BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with carriers to process Medicare Part B claims submitted by physicians and medical suppliers (providers).

### Medicare Part B Carriers

Prior to October 1, 2005, section 1842(a) of the Act authorized CMS to contract with carriers to process and pay Medicare Part B claims submitted by providers. [1] Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process providers' claims, carriers currently use the Medicare Multi-Carrier Claims System (MCS) and CMS's Common Working File (CWF). These systems can detect certain improper payments during prepayment validation.

CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. During calendar years (CY) 2004–2006, providers nationwide submitted approximately 2.4 billion claims to carriers. Of these, 31,576 claims resulted in payments of $10,000 or more (high-dollar payments). We consider such claims to be at risk for overpayment.

### CIGNA Government Services

CIGNA Government Services (CGS) has been a Medicare contractor for CMS since the inception of the Medicare program in 1966. CGS processes Part B and Durable Medical Equipment claims. CGS used the Medicare Viable Information Processing System (VIPS) to process claims until March 2005 and began processing new claims using the MCS by April 2005.[2]

Under contract with CMS, CGS is responsible for Part B claims processing in Idaho, Tennessee, and North Carolina. During CYs 2004–2006, CGS carriers processed approximately 144 million Medicare Part B claims. CGS carrier No. 05440 (the contractor) is the Medicare Part B carrier for about 23,900 providers in Tennessee. During CYs 2004–2006, the contractor used the VIPS and MCS to process approximately 58 million Part B claims,[3] 1,131 of which were high-dollar payments. These high-dollar payments totaled $27,229,897.

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[1]The Medicare Modernization Act of 2003, P. L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace carriers and fiscal intermediaries by October 2011.

[2]CMS required carriers to transition to the MCS beginning in 2002. Before that time, carriers could use either the VIPS or the MCS.

[3]CGS used the VIPS to process Part B claims until March of 2005.

We examined Part B high-dollar payments for CGS carrier No. 05535 (A-04-08-00043) under a separate review.

**"Medically Unlikely" Edits**

In January 2007, after our audit period, CMS required carriers to implement units-of-service edits referred to as "medically unlikely" edits. These edits are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the "Medicare Program Integrity Manual," Publication 100-08, Transmittal 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, Healthcare Common Procedure Coding System code, date of service, and billing provider against a specified number of units of service. Carriers must deny the entire claim line when the units of service billed exceed the specified number.

## OBJECTIVE, SCOPE, AND METHODOLOGY

### Objective

Our objective was to determine whether CGS high-dollar payments to Tennessee Part B providers were appropriate.

### Scope

We reviewed the 1,131 high-dollar payments, totaling $27,229,897, that the contractor processed during CYs 2004–2006.

We limited our review of the contractor's internal controls to those controls applicable to the 1,131 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our fieldwork from January 2008 through June 2008 by working with CGS, located in Nashville, Tennessee, and providers that received high-dollar payments.

### Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify Part B claims with high-dollar Medicare payments;
- reviewed available CWF claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;

- contacted providers to determine whether high-dollar claims were billed and paid correctly and, if not, why the claims were billed or paid incorrectly; and

- coordinated our claim review with the contractor.

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 RECOMMENDATION

The contractor appropriately made 1,111 of the 1,131 high-dollar payments to Tennessee providers. However, we identified 20 overpayments totaling $204,579. Generally, the contractor made the overpayments because the providers incorrectly billed excessive units of service. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004–2006 to detect and prevent payments for these types of erroneous claims.

### MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Publication 14, Part 2, section 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and general instructions. Section 5261.3 of the manual requires carriers to effectively and continually analyze "data that identifies aberrancies, emerging trends and areas of potential abuse, overutilization or inappropriate care, and . . . areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

### INAPPROPRIATE HIGH-DOLLAR PAYMENTS

We identified 20 overpayments totaling $204,579. For 18 overpayments totaling $204,510, providers incorrectly billed the contractor for excessive units of service. In aggregate, providers billed 1,942 excessive units of service. Examples of these errors follow:

- One provider billed 500 units for basic radiation dosimetry calculation on a claim that should have been billed as 15 units of service. This error resulted in 485 excess units of service claimed and an overpayment of $12,012.

- One provider billed 70 units for the drug Doxil on a claim that should have been billed as 7 units of service. This error resulted in 63 excess units of service claimed and an overpayment of $19,715.

- One provider billed 400 units for nerve conduction on a claim that should have been billed as 4 units of service. This error resulted in 396 excess units of service claimed and an overpayment of $20,601.

- One provider billed 460 units of the drug Trastuzumab on a claim that should have been billed as 46 units of service. This error resulted in 414 excess units of service claimed and an overpayment of $17,226.

For two overpayments totaling $69, we were unable to determine whether the provider billed the claim incorrectly or the contractor paid the claim incorrectly. However, we identified overpayments relating to incorrect rates paid (on a per unit basis) as follows:

- One provider received payment for the drug Recombinate on a claim and reported an overpayment of $40.

- One provider received payments for the drug Benefix on four claims and reported an overpayment of $29.

Generally, providers attributed the incorrect claims to clerical errors made by their billing staffs. In addition, during CYs 2004–2006, the VIPS, MCS, and CWF did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service. Instead, CMS relied on providers to notify the carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[4]

## RECOMMENDATION

We recommend that the contractor recover the $204,579 in identified overpayments.

## AUDITEE COMMENTS

In written comments on the draft report, CIGNA Government Services stated that it had adjusted these 20 claims and was pursuing the associated overpayments. CGS's comments are included in their entirety as the Appendix.

[4]The carrier sends a "Medicare Summary Notice" to the beneficiary after the provider files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

# APPENDIX

**Brian D. Setzer**
Vice President

**CIGNA** Government Services

Two Vantage Way
Nashville, TN 37228
Telephone 615.782.4618
Facsimile 615.782.4695
Brian.Setzer@CIGNA.com

December 18, 2008

Peter J. Barbera
Regional Inspector General for Audit Services
DHHS/OIG/OAS/Region IV
61 Forsyth Street, S.W., Ste. 3T41
Atlanta, GA 30303

Dear Mr. Barbera,

On November 24, 2008, CIGNA Government Services (CGS) received Draft Report A-04-08-00045: Review of High-Dollar Part B Claims Processed by CGS Carrier No. 05440 for the period of January 1, 2004, through December 31, 2006. CGS has reviewed the 20 high-dollar payments identified in the report as overpayments. Due to record retention limitations, 14 of the 20 claims were purged from the claims system and required a manual account receivable record to be created. To date CGS has successfully adjusted these 20 claims and is pursuing the associated overpayments.

If you have any questions or additional requests related to this review, please contact Karina Houston, Compliance Specialist at 615-782-4435.

Sincerely,

Brian D Setzer

Brian D. Setzer
Vice President
CIGNA Government Services