Office of Audit Services
Region I
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OCT 17 2008

Report Number: A-01-08-00521

Mr. James Elmore
Regional Vice President, Contract Administration
National Government Services, Inc.
8115-8125 Knue Road
Indianapolis, Indiana 46250

Dear Mr. Elmore:

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 National Government Services, Inc., of Massachusetts for Calendar Years 2004 and 2005." 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 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 Leah Scott, Audit Manager, at (617) 565-2679 or through e-mail at Leah.Scott@oig.hhs.gov. Please refer to report number A-01-08-00521 in all correspondence.

Sincerely,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management and 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 PAYMENTS FOR MEDICARE OUTPATIENT CLAIMS PROCESSED BY NATIONAL GOVERNMENT SERVICES, INC., OF MASSACHUSETTS FOR CALENDAR YEARS 2004 AND 2005

Daniel R. Levinson
Inspector General

October 2008
A-01-08-00521

Office of Inspector General

http://oig.hhs.gov

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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 fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims.

Federal guidance provides that intermediaries should maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. In addition, Medicare guidance requires hospitals to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of service as the number of times that a service or procedure was performed.

During calendar years (CY) 2004 and 2005, Associated Hospital Service was the fiscal intermediary for Massachusetts. Associated Hospital Service processed over 7 million outpatient claims in Massachusetts during this period, 11 of which resulted in payments of $50,000 or more (high-dollar payments). In January 2007, National Government Services, Inc., of Massachusetts (NGS-MA) assumed the business operations of Associated Hospital Service.

OBJECTIVE

Our objective was to determine whether NGS-MA's high-dollar Medicare payments to hospitals for outpatient services were appropriate.

SUMMARY OF FINDING

Of the 11 high-dollar payments that NGS-MA made for outpatient services during CYs 2004 and 2005, only 1 was appropriate. The remaining 10 payments were for claims with provider billing errors that resulted in overpayments totaling $728,395. The providers had identified and refunded $718,175 of the overpayments before our audit began. As a result, Medicare was due a refund of $10,220.

NGS-MA made the overpayments because it did not have sufficient prepayment or postpayment controls in place during CYs 2004 and 2005 to identify erroneous claims. In addition, the CWF did not have sufficient edits in place during CYs 2004 and 2005 to detect and prevent excessive payments.

RECOMMENDATIONS

We recommend that NGS-MA:

- ensures that the provider who received the unrefunded overpayment submits an adjustment for $10,220 and

- identifies and reviews all high-dollar claims.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In comments on our draft report, NGS agreed with our finding and recommendations. NGS'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 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. In addition, Medicare guidance requires hospitals to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes.

To process hospitals' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System (FISS) and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

In calendar years (CY) 2004 and 2005, fiscal intermediaries processed and paid over 278 million outpatient claims, 989 of which resulted in payments of $50,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

National Government Services - Massachusetts

During CYs 2004 and 2005, Associated Hospital Service was the fiscal intermediary in Massachusetts. Associated Hospital Service processed over 7 million outpatient claims in Massachusetts during this period, 11 of which resulted in high-dollar payments. In January 2007, National Government Services, Inc., of Massachusetts (NGS-MA) assumed the business operations of Associated Hospital Service.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether NGS-MA's high-dollar Medicare payments to hospitals for outpatient services were appropriate.

Scope

We reviewed the 11 high-dollar payments totaling approximately $886,000 for outpatient claims from Massachusetts hospitals that NGS-MA processed during CYs 2004 and 2005.

We limited our review of NGS-MA's internal controls to those applicable to the 11 payments 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 performed our audit work from March through June 2008. Our audit work included contacting NGS-MA, headquartered in Indianapolis, Indiana, and the hospitals that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient claims with high-dollar 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 the hospitals 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 hospitals agreed that refunds were appropriate; and
- validated with NGS-MA that overpayments had occurred and refunds were appropriate.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the 11 high-dollar payments that NGS-MA made for outpatient services during CYs 2004 and 2005, only 1 was appropriate. The remaining 10 payments were for claims with provider billing errors that resulted in overpayments totaling $728,395. The providers had identified and refunded $718,175 of the overpayments before our audit began. As a result, Medicare was due a refund of $10,220.

NGS-MA made the overpayments because it did not have sufficient prepayment or postpayment controls in place during CYs 2004 and 2005 to identify erroneous claims. In addition, the CWF

did not have sufficient edits in place during CYs 2004 and 2005 to detect and prevent excessive payments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. 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" 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 HIGH-DOLLAR PAYMENTS

NGS-MA made 10 overpayments totaling $728,395 because providers either claimed excessive units of service or reported incorrect HCPCS codes. The providers had identified and refunded $718,175 of the overpayments before the start of our audit. The provider who received the un-refunded overpayment agreed, after reviewing the claim in question, that Medicare was due an additional refund of $10,220.

The following examples illustrate the types of errors found:

- One provider billed 3,000 units of service for 3 units delivered. The provider stated that it had mistakenly entered the wrong number of units because of human error. As a result, NGS-MA paid the provider $82,577 when it should have paid $55, an overpayment of $82,522.

- One provider billed procedure code J9217 (leuprolide acetate) rather than procedure code Q0137 (darbepoetin alfa). Although the provider acknowledged the billing error, it did not specify the cause. As a result, NGS-MA paid the provider $80,657 when it should have paid $586, an overpayment of $80,071.

CAUSES OF OVERPAYMENTS

NGS-MA made the overpayments because it did not have sufficient prepayment or postpayment controls to identify erroneous payments at the claim level during CYs 2004 and 2005. Further, the CWF lacked prepayment edits to detect and prevent excessive payments. In effect, CMS

relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Medicare Summary Notice" and disclose any overpayments.[1]

FISCAL INTERMEDIARY PREPAYMENT EDIT

On January 3, 2006, CMS began requiring intermediaries to implement a FISS edit to suspend high-dollar outpatient claims until intermediaries had conducted a prepayment review to determine the legitimacy of the claims.

According to NGS-MA, it had an edit in place before January 1, 2006, that suspended claims with reimbursement amounts greater than $150,000 for review. To comply with the new CMS requirement, NGS-MA changed its edit to suspend claims with reimbursement amounts of $50,000 or more for review. The claims department reviews the claim for provider verification of units and charges billed. If the provider has verified that the units and charges are correct, NGS-MA processes the claim. NGS-MA returns unverified claims to the provider, who must then resubmit the claim. NGS-MA did not make any high-dollar payments in 2006.

RECOMMENDATIONS

We recommend that NGS-MA:

- ensures that the provider who received the unrefunded overpayment submits an adjustment for $10,220 and

- identifies and reviews all high-dollar claims.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In comments on our draft report, NGS agreed with our finding and recommendations. NGS's comments are included in their entirety as the Appendix.

[1]The fiscal intermediary sends a "Medicare Summary 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

National Government Services, Inc.
P.O. Box 7181
Indianapolis, Indiana 46207-7181
A CMS Contracted Agent

October 7, 2008

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: Response to Draft Report Number A-01-08-00521

This letter is in response to the above referenced draft entitled "Review of High-Dollar Payments for Medicare Outpatient Claims Processed by National Government Services Inc., of Massachusetts for Calendar Years 2004 and 2005."

National Government Services (NGS) agrees with the audit recommendations noted in the draft report and offers the following comments:

1. The provider has been contacted relative to the one outstanding overpayment of $10,220. NGS will monitor the claim to ensure corrective action is taken by the provider. If a response and/or adjustment has not been completed within 30 days, NGS will take appropriate actions to recover the monies.
2. The Fiscal Intermediary Shared System (FISS) installed an edit during the January 2006 release, which suspended all outpatient claims where the reimbursement amount is greater than $50,000 for review. Therefore, since all claims processed after this audit were subject to this edit and review, NGS does not feel any additional review is warranted at this time.

NGS appreciates the opportunity to respond to the draft report. Should you have further questions, please feel free to contact Sarah Litteral, Claims Director, at 502-329-8584.

Sincerely,

David Crowley
Staff Vice President
Claims Management

Cc: Sarah Litteral, Part A/RHHI Claims Director