DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

Report Number: A-06-08-00041

December 1, 2008

Mr. Jimmy Chaney
Director of Medical Claims
TriSpan Health Services
1064 Flynt Drive
Flowood, Mississippi 39232-9750

Dear Mr. Chaney:

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 Part A 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 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 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-06-08-00041 in all correspondence.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nan 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 PAYMENTS FOR MEDICARE PART A OUTPATIENT CLAIMS PROCESSED BY TRISPAN HEALTH SERVICES FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 2004

Daniel R. Levinson
Inspector General

December 2008
A-06-08-00041

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 to process 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 Part A fiscal intermediary serving more than 1,800 Medicare providers in Mississippi, Louisiana, and Missouri. For calendar year (CY) 2004, TriSpan processed approximately 3.7 million outpatient claims, 20 of which resulted in payments of $50,000 or more (high-dollar payments). Sixteen of those claims were from 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 claims in Jurisdiction 5, which includes the states of Iowa, Kansas, Missouri, and Nebraska. As a result, WPS became responsible for Missouri. Therefore, this report will include only 4 of the 20 claims; we will report the remaining 16 claims to WPS.

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 four high-dollar payments that TriSpan made to providers, one was appropriate. TriSpan overpaid providers for three claims, resulting in overpayments totaling $203,478. Contrary to Federal guidance, the providers inappropriately overstated the units of service in each of the three high-dollar claims for procedure codes Q0136 and J9293. TriSpan made the overpayments 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.

RECOMMENDATIONS

We recommend that TriSpan:

- review claims under $50,000 that bill the procedure codes identified in this report and correct any claims found in error and

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

TRISPAN HEALTH SERVICES COMMENTS

In its comments on our draft report, TriSpan agreed with our findings and second recommendation and partially agreed with our first recommendation. The full text of TriSpan'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 claims, 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 claims for prepayment validation.

In calendar year (CY) 2004, fiscal intermediaries processed and paid more than 136 million outpatient claims, 588 of which resulted in payments of $50,000 or more (high-dollar payments). We considered such claims 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 Part A fiscal intermediary serving more than 1,800 Medicare providers in Mississippi, Louisiana, and Missouri. For claims in CY 2004, TriSpan processed approximately 3.7 million outpatient claims, 20 of which resulted in payments of $50,000 or more (high-dollar payments). Sixteen of the claims were from 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 claims in Jurisdiction 5, which includes the states of Iowa, Kansas, Missouri, and Nebraska. As a result, WPS became responsible for Missouri. Therefore, this report will include only 4 of the 20 claims; we will report the remaining 16 claims to WPS.

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 four high-dollar payments for outpatient claims that TriSpan processed for Mississippi and Louisiana providers. We limited our review of TriSpan's internal controls to those applicable to the four 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 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.

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 claim 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 TriSpan.

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 four high-dollar payments that TriSpan made to providers, one was appropriate. TriSpan overpaid providers for three claims, resulting in overpayments totaling $203,478. Contrary to Federal guidance, the providers inappropriately overstated the units of service in each of the

three high-dollar claims. TriSpan made the overpayments 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.

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. CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states that the number 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 the manual states: "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

TriSpan made three overpayments totaling $203,478 because two providers billed for excessive units of service.

- For two claims from one provider, the provider billed 6,000 units of service for 60 units delivered for each claim. The provider stated that procedure code Q0136 should have been billed as 1 unit per 1,000 units dispensed. As a result, TriSpan paid the provider $139,519 when it should have paid $1,247, an overpayment of $138,272. The provider refunded the overpayment on the claims during our audit.

- For one claim, the provider billed procedure code J9293 for 200 units of service for 2 units delivered but did not provide an explanation for the billing error. As a result, TriSpan paid the provider $65,928 when it should have paid $722, an overpayment of $65,206. The provider refunded the overpayment during our audit.

CAUSES OF OVERPAYMENTS

The providers agreed that overpayments had occurred and refunded the overpayment amounts. One provider attributed the incorrect claim to its 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 claim 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. The edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

RECOMMENDATIONS

We recommend that TriSpan:

- review claims under $50,000 that bill the procedure codes identified in this report and correct any claims found in error and

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

TRISPAN HEALTH SERVICES COMMENTS

In its comments on our draft report, TriSpan agreed with our findings and second recommendation and partially agreed with our first recommendation. In response to the first recommendation, TriSpan said that it plans to obtain a listing of the universe of claims from the Fiscal Intermediary Standard System that meet the criteria described in the recommendation and review a random sample of those claims to determine whether there are a significant number of inappropriately billed claims. TriSpan stated that if the number is high, it will expand the scope of its review to possibly include the entire universe of claims. We agree with TriSpan's proposal.

In response to the second recommendation, TriSpan said that it plans to publish frequently asked questions on its Web site to educate its providers on the proper billing of units for HCPCS codes Q0136 and J9293. TriSpan also said that it plans to include the information in any applicable presentations or teleconferences it holds for providers.

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

[1]The fiscal intermediary sends an "Explanation of Medicare Benefits" 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

TRISPAN
HEALTH SERVICES, INC.
MEDICARE PART A INTERMEDIARY
A CMS Contracted Intermediary

www.trispan.com
P. O. Box 23046 • Jackson, MS • 39225-3046

October 30, 2008

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

Dear Mr. Sato:

This letter provides written comments from TriSpan Health Services, Inc. related to the Office of Inspector General (OIG) draft report number A-06-08-00041 entitled "Review of High-Dollar Payments for Medicare Part A Outpatient Claims Processed by TriSpan Health Services for the Period January 1 Through December 31, 2004."

For calendar year (CY) 2004, TriSpan processed approximately 3.7 million outpatient claims, 20 of which resulted in payments of $50,000 or more (high-dollar payments). Only 4 of the 20 claims were included in the report because 16 of the 20 claims were from Missouri providers which were transitioned to Wisconsin Physicians Service Insurance Corporation (WPS) in May 2008.

The audit objective was to determine whether the high-dollar Medicare payments that TriSpan made to hospitals for outpatient services were appropriate. The OIG 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.

Three of the four high-dollar payments that TriSpan made for outpatient services for CY 2004 were not appropriate. The amount of the overpayment totaled $203,478. The providers inappropriately overstated the units of service in each of the three high-dollar claims. TriSpan made the overpayments 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.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

TriSpan made three overpayments totaling $203,478 because two providers billed for excessive units of service.

- For two claims from one provider, the provider billed 6,000 units of service for 60 units (HCPCS Q0136) delivered for each claim. The provider refunded the overpayment of $138,272 during the audit.

- For one claim, the provider billed 200 units of service for 2 units (HCPCS J9293) delivered. The provider refunded the overpayment of $65,206 during the audit.

In the OIG draft report, there were two recommendations:

1) that TriSpan review claims under $50,000 that bill the procedure codes identified in this report (Q0136 and J9293) and correct any claims found in error and

2) that TriSpan use the results of the audit in its provider education activities.

In response to the first recommendation, we plan to obtain a listing of the universe of claims from the FISS that meet the criteria described in the recommendation. We will review a random sample of the claims in the universe to determine if a significant number of inappropriately billed claims exist. If the number is high, we will have to expand the scope of our review to possibly include the entire universe of claims. Providers will be asked to submit adjustment claims to correct the incorrectly billed units of service.

In response to the second recommendation, we plan to publish Frequently Asked Questions on our Web site to educate our providers on the proper billing of units for HCPCS codes Q0136 and J9293. We will also include this information in any applicable presentations or teleconferences held for our provider community during the fiscal year.

The standard system currently has edits in place to suspend high-dollar outpatient claims for review, and there are some local edits in place for excessive units for services identified through data analysis and Comprehensive Error Rate Testing (CERT) findings. TriSpan will continue to add local edits as needed and educate providers on proper billing of units of service.

If you have any questions or comments regarding this letter, please feel free to call Jimmy Chaney at (601) 664-4229.

Sincerely,

Jennifer Sumrall

Jennifer Sumrall
Manager, Medicare Claims, Customer Service, Outreach and Education
TriSpan Health Services, Inc.