



Office of Audit Services, Region III  
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NOV 12 2008

Report Number: A-03-07-00014

Mr. Jamie Bylotas  
Director, Quality & Performance Management  
Highmark Medicare Services  
1800 Center Street  
Camp Hill, Pennsylvania 17089

Dear Mr. Bylotas:

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 Maryland and District of Columbia Medicare Hospital Outpatient Claims Processed by Highmark Medicare Services for the Period October 1 Through December 31, 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 at (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through e-mail at [Bernard.Siegel@oig.hhs.gov](mailto:Bernard.Siegel@oig.hhs.gov). Please refer to report number A-03-07-00014 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky  
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 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR  
PAYMENTS FOR MARYLAND AND  
DISTRICT OF COLUMBIA  
MEDICARE HOSPITAL OUTPATIENT  
CLAIMS PROCESSED BY HIGHMARK  
MEDICARE SERVICES FOR THE  
PERIOD OCTOBER 1 THROUGH  
DECEMBER 31, 2005**



Daniel R. Levinson  
Inspector General

November 2008  
A-03-07-00014

# *Office of Inspector General*

<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 fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments. 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.

Fiscal intermediaries currently use the Fiscal Intermediary Standard System and CMS's Common Working File to process hospital outpatient claims. These systems can detect certain improper payments during prepayment validation.

Prior to October 1, 2005, CareFirst of Maryland was the Medicare fiscal intermediary for Maryland and the District of Columbia. On October 1, 2005, Highmark Medicare Services (Highmark) assumed the fiscal intermediary operations for Maryland and the District of Columbia. During the period October 1 through December 31, 2005, Highmark processed over 600,000 outpatient claims, 5 of which resulted in payments of \$50,000 or more (high-dollar payments).

### **OBJECTIVE**

Our objective was to determine whether high-dollar Medicare payments that Highmark made to hospitals for outpatient services as the fiscal intermediary for Maryland and the District of Columbia were appropriate.

### **SUMMARY OF FINDING**

Highmark overpaid \$53,524 for the five high-dollar payments it made for hospital outpatient claims in Maryland and the District of Columbia. One hospital refunded one overpayment totaling \$49,789 prior to our audit. As a result of discussions during the audit, two hospitals refunded two overpayments totaling \$674; however, one hospital had not refunded two overpayments totaling \$3,061.

Highmark made the overpayments because three hospitals incorrectly claimed the wrong service or incorrect units of service on five claims. In addition, neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during the audit period to detect and prevent payments for these types of erroneous claims.

### **RECOMMENDATION**

We recommend that Highmark recover the \$3,061 in identified overpayments for high-dollar claims.

## **HIGHMARK MEDICARE SERVICES COMMENTS**

In comments on our draft report (Appendix), Highmark stated that it concurred with our recommendation and initiated activity recover the \$3,061 in identified overpayments. Highmark's comments are 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 process and pay Medicare Part B claims submitted by hospital outpatient departments (hospital) among other things. Fiscal 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 hospital outpatient claims, fiscal intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

During calendar years (CY) 2003–05, fiscal intermediaries processed and paid approximately 409 million outpatient claims, 1,243 of which resulted in payments of \$50,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

#### **Claims for Outpatient Services**

Hospitals submit bills to fiscal intermediaries for outpatient services identifying each service by type and number of units of service performed on a separate line of the claim. Fiscal intermediaries calculate a payment for each service based on the individual line billed. Medicare guidance requires hospitals to submit accurate claims for outpatient services. Hospitals should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed.

#### **Highmark Medicare Services**

Prior to October 1, 2005, CareFirst of Maryland was the Medicare fiscal intermediary for Maryland and the District of Columbia. On October 1, 2005, Highmark Medicare Services (Highmark) assumed the fiscal intermediary operations for Maryland and the District of Columbia<sup>1</sup>. During the period October 1 through December 31, 2005, Highmark processed over 600,000 outpatient claims, 5 of which were high-dollar payments.

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<sup>1</sup>Our report, "Review of High-Dollar Payments for Maryland and the District of Columbia Medicare Outpatient Claims Processed by CareFirst of Maryland for the Period January 1, 2003, Through September 30, 2005," (A-03-07-00012), will include claims processed and paid by CareFirst of Maryland as the fiscal intermediary for Maryland and the District of Columbia from January 1, 2003, through September 30, 2005.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether high-dollar Medicare payments that Highmark made to hospitals for outpatient services as the fiscal intermediary for Maryland and the District of Columbia were appropriate.

### **Scope**

We reviewed the five high-dollar payments for hospital outpatient claims totaling \$358,355 that Highmark processed from October 1 through December 31, 2005. We limited our review of Highmark's internal controls to those applicable to the five 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 audit from March through July 2008.

### **Methodology**

To accomplish our objectives, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare Part B hospital outpatient claims with high-dollar payments;
- reviewed available Common Working File data 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 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;
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments; and
- validated with Highmark that overpayments 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 findings and conclusions based on our audit objectives.

## **FINDINGS AND RECOMMENDATIONS**

Highmark overpaid \$53,524 for the five high-dollar payments it made for hospital outpatient claims in Maryland and the District of Columbia. One hospital refunded one overpayment totaling \$49,789 prior to our audit. As a result of discussions during the audit, two hospitals refunded two overpayments totaling \$674; however, one hospital had not refunded two overpayments totaling \$3,061.

Highmark made the overpayments because three hospitals incorrectly claimed the wrong service or incorrect units of service on five claims. In addition, neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during the audit period to detect and prevent payments for these types of erroneous claims.

### **MEDICARE REQUIREMENTS**

Section 9343 of the Omnibus Budget Reconciliation Act of 1986, P. L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. The CMS “Medicare Claims Processing Manual,” Pub. No. 100-04, chapter 4, § 20.4, states: “The definition of service units . . . is the number of times the service or procedure being reported was performed.” Chapter 1, § 80.3.2.2 of the manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

Section 3700 of the “Medicare Intermediary Manual,” states that “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**

Highmark overpaid hospitals \$53,524 for five payments. For the five overpayments, three hospitals incorrectly billed Highmark for the wrong service or incorrect units of service. One hospital refunded one overpayment totaling \$49,789 prior to our audit. As a result of discussions during the audit, two hospitals refunded two overpayments totaling \$674; however, one hospital had not refunded two overpayments totaling \$3,061.

- One hospital billed for a total of 1,000 units of bevacizumab, a chemotherapy drug, instead of 100 units. As a result, Highmark paid \$55,321 when it should have paid \$5,532, an overpayment of \$49,789. The hospital refunded the overpayment prior to our audit.
- One hospital billed for excessive units of service on three claims.

- For one claim the hospital billed for non-chemotherapy infusions instead of chemotherapy intravenous injections and for incorrect units of service for the injections. As a result, Highmark paid \$38,634 instead of \$36,037, an overpayment of \$2,597.
- For one claim the hospital billed for non-chemotherapy infusions instead of chemotherapy intravenous injections and for incorrect units of service for the injections. As a result, Highmark paid \$34,830 when it should have paid \$34,366, an overpayment of \$464.
- For one claim the hospital billed 17 units for pharmacy items instead of 8 units. As a result, Highmark paid \$17 when it should have paid \$6, an overpayment of \$11. The hospital refunded the overpayment as result of our audit.
- One provider billed for a total of 12 units of chemotherapy administration infusion instead of 3 units. As a result, Highmark paid \$1,205 when it should have paid \$542, an overpayment of \$663. The hospital refunded the overpayment as result of our audit.

## **INSUFFICIENT PREPAYMENT OR POSTPAYMENT CONTROLS**

During our audit period, Highmark did not have prepayment or postpayment controls to identify aberrant payments at the claim level, and the Common Working File 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.<sup>2</sup>

## **FISCAL INTERMEDIARY PREPAYMENT EDIT**

On January 3, 2006, after 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.

## **RECOMMENDATION**

We recommend that Highmark recover the \$3,061 in identified overpayments for high-dollar claims.

## **HIGHMARK MEDICARE SERVICES COMMENTS**

In comments on our draft report Highmark stated that it concurred with our recommendation and initiated activity recover the \$3,061 in identified overpayments. Highmark’s comments are included as the appendix.

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<sup>2</sup>The fiscal intermediary sends a “Medicare Summary Notice” notice to the beneficiary after the hospital file a claim for outpatient services. The notice explains the services provided, the amount charged, and the amount that may be billed to the beneficiary.

# **APPENDIX**



Stephen Virbitsky  
Regional Inspector General for Audit Services  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

November 4, 2008

RE: OIG Report Number A-03-07-0014

Dear Mr. Virbitsky:

Attached is the Highmark Medicare Services' response to your request for comments on the draft report entitled, "Review of High-Dollar Payments for Maryland and District of Columbia Medicare Hospital Outpatient Claims Processed by Highmark Medicare Services for the Period October 1 through December 31, 2005."

Please do not hesitate to contact me at (717) 302-4410 if you have any questions.

Sincerely,

A handwritten signature in black ink that reads "E. James Bylotas".

E. James Bylotas  
Director, Quality and Performance Management

CC: Bernard Siegel

## **Highmark Medicare Services Response to OIG Audit A-03-07-0014**

### **I. Inappropriate High-Dollar Payment**

“Highmark overpaid hospitals \$53,524 for five payments. For the five overpayments, three hospitals incorrectly billed Highmark for the wrong service or incorrect units of service. One hospital refunded one overpayment totaling \$49,789 prior to our audit. As a result of discussions during the audit, two hospitals refunded two overpayments totaling \$674; however, one hospital had not refunded two overpayments totaling \$3,061.”

#### **Recommendation**

“We recommend Highmark recover the \$3,061 in identified overpayments for high-dollar claims.”

#### **Highmark Medicare Services Response**

We agree the overpayments were the result of incorrectly billed by the providers. We concur with the recommendation and have initiated activity to recover the identified overpayments for high-dollar claims.

### **II. Insufficient Prepayment or Postpayment Controls**

“During our audit period, Highmark did not have prepayment or postpayment controls to identify aberrant payments at the claim level, and the Common Working File lacked prepayment edits to detect and prevent excessive payments. In effect, CMS relied on hospitals to notify fiscal intermediaries or excessive payments and on beneficiaries to review their ‘Medicare Summary Notice’ and disclose any overpayments.”

#### **Highmark Medicare Services Response**

We agree that we did not have, nor did CMS require contractors to have, prepayment edits in place during the period of the audit to identify aberrant payments at the claim level, and the Common Working File lacked prepayment edits to detect and prevent excessive payments. However, during the audit period, we did, and continue to conduct postpayment data analysis that could capture aberrant number of units billed and aberrant billing patterns. Additionally, Highmark Medicare Services has implemented a Medically Unlikely Edit (MUE) to suspend potentially excessive Medicare Payments for prepayment review as required by CMS. We have also established our own “Clinically Unlikely Edits (CUE).