APR 2 1 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of High-Dollar Payments for Services Processed by Wisconsin Physicians Service for the Period January 1, 2004, Through December 31, 2006 (A-05-08-00022)

Attached is an advance copy of our final report on high-dollar payments for services processed by Wisconsin Physicians Service (WPS) for the period January 1, 2004, through December 31, 2006. We will issue this report to WPS within 5 business days. This audit was part of a nationwide review of payments for Medicare Part B services of $10,000 or more (high-dollar payments).

Our objective was to determine whether high-dollar Medicare payments that WPS made to Part B providers for services provided during calendar years (CY) 2004 through 2006 were appropriate.

Of the 100 sampled high-dollar payments that WPS made to Part B providers for services provided during CYs 2004 through 2006, 77 were appropriate. The 23 remaining payments included net overpayments totaling $117,778, of which $95,736 for 20 payments had not been refunded at the start of our audit.

WPS made the overpayments because its staff inaccurately calculated or entered the payment rates for manually processed claims or because providers reported inaccurate units of service. In addition, the Medicare claim-processing systems did not have sufficient computer edits or manual pricing controls in place during CYs 2004 through 2006 to detect and prevent payments for these types of erroneous claims.

Based on the sample results for our 3-year audit period, we estimated that WPS made 402 overpayments totaling $2,057,585 to providers in Illinois, Michigan, Minnesota, and Wisconsin for Part B services.

We recommend that WPS:

- recover the $95,736 in identified overpayments,
- review the 1,647 remaining high-dollar payments with potential overpayments estimated at $1,939,807 ($2,057,585 less $117,778 overpaid) and work with the providers that claimed these services to recover any overpayments,
- consider reviewing high-dollar payments made for services provided after CY 2006 and recover any additional overpayments, and
- improve internal controls related to manual claim processing.

In written comments on our draft report, WPS described corrective actions that it had taken or planned to take to implement our recommendations.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at George.Reeb@oig.hhs.gov or Marc Gustafson, Regional Inspector General for Audit Services, Region V, at (312) 353-2618 or through e-mail at Marc.Gustafson@oig.hhs.gov. Please refer to report number A-05-08-00022.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

APR 24 2009

Report Number: A-05-08-00022

Mr. Guy Ringle
Senior Vice-President, Medicare
Wisconsin Physicians Service Insurance Corporation
P.O. Box 1787
Madison, Wisconsin 53701

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 Services Processed by Wisconsin Physicians Service for the Period January 1, 2004, Through December 31, 2006." 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, or contact Sheri Fulcher, Audit Manager, at (312) 353-1823 or through e-mail at Sheri.Fulcher@oig.hhs.gov. Please refer to report number A-05-08-00022 in all correspondence.

Sincerely,

Marc L. Gustafson
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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR SERVICES PROCESSED BY WISCONSIN PHYSICIANS SERVICE FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2006

Daniel R. Levinson
Inspector General

April 2009
A-05-08-00022

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

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 carriers to pay for physician services based on a fee schedule and to pay for drugs based on the CMS published average sales price. CMS guidance also requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. Carriers 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.

Wisconsin Physicians Service (WPS) is the Medicare Part B carrier for approximately 100,000 providers in Illinois, Michigan, Minnesota, and Wisconsin. During calendar years (CY) 2004 through 2006, WPS processed more than 274 million Part B claims, 1,747 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that WPS made to Part B providers for services provided during CYs 2004 through 2006 were appropriate.

SUMMARY OF FINDING

Of the 100 sampled high-dollar payments that WPS made to Part B providers for services provided during CYs 2004 through 2006, 77 were appropriate. The 23 remaining payments included net overpayments totaling $117,778, of which $95,736 for 20 payments had not been refunded at the start of our audit.

WPS made the overpayments because its staff inaccurately calculated or entered the payment rates for manually processed claims or because providers reported inaccurate units of service. In addition, the Medicare claim-processing systems did not have sufficient computer edits or manual pricing controls in place during CYs 2004 through 2006 to detect and prevent payments for these types of erroneous claims.

Based on the sample results for our 3-year audit period, we estimated that WPS made 402 overpayments totaling $2,057,585 to providers in Illinois, Michigan, Minnesota, and Wisconsin for Part B services.

RECOMMENDATIONS

We recommend that WPS:

- recover the $95,736 in identified overpayments,

- review the 1,647 remaining high-dollar payments with potential overpayments estimated at $1,939,807 ($2,057,585 less $117,778 overpaid) and work with the providers that claimed these services to recover any overpayments,

- consider reviewing high-dollar payments made for services provided after CY 2006 and recover any additional overpayments, and

- improve internal controls related to manual claim processing.

WISCONSIN PHYSICIANS SERVICE COMMENTS

In written comments on our draft report, WPS described corrective actions that it had taken or planned to take to implement our recommendations. WPS's comments are included in their entirety as Appendix C.

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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) administers the program.

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 physicians and medical suppliers (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 use the Medicare Multi-Carrier Claims System and CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

CMS guidance requires carriers to pay for physician services based on a fee schedule and to pay for certain drugs based on the CMS published average sales price. CMS guidance also 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 through 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 high risk for overpayment.

Wisconsin Physicians Service

Wisconsin Physicians Service (WPS) is the Medicare Part B carrier for approximately 100,000 providers in Illinois, Michigan, Minnesota, and Wisconsin. During CYs 2004 through 2006, WPS processed more than 274 million Part B claims, 1,747 of which resulted in high-dollar payments.

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 were designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the "Medicare Program Integrity Manual," Pub. No. 100-08, Transmittal 178, Change Request 5402 (December 8, 2006), 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. In

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

2007, WPS instituted medically unlikely edits and targeted certain high-dollar medical procedures for review.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that WPS made to Part B providers for services provided during CYs 2004 through 2006 were appropriate.

Scope

We reviewed a statistical sample of 100 payments totaling $2,051,469 from the 1,747 high-dollar payments totaling $35,419,979 that WPS made for services provided during CYs 2004 through 2006.

We limited our review of WPS's internal controls to those applicable to the 100 sampled 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 performed our fieldwork from October 2007 through October 2008 by coordinating with WPS in Madison, Wisconsin, and by contacting the providers that received the sampled 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 Medicare Part B claims with high-dollar payments;
- identified the computer system edits and manual claim-processing controls that WPS had in place to prevent overpayments for Part B high-dollar medical procedures;
- selected a simple random sample of 100 payments totaling $2,051,469 from the sampling frame of 1,747 high-dollar payments that WPS processed for services provided during CYs 2004 through 2006 (Appendix A);
- reviewed available Common Working File claim histories for the 100 sampled payments and determined whether the claims had been canceled and superseded by revised claims and whether payments remained outstanding at the time of our fieldwork;

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

- coordinated our review, including the calculation of any overpayments, with WPS officials; and

- used our sample results to estimate the number and dollar amount of the overpayments in the sampling frame (Appendix B).

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 100 sampled high-dollar payments that WPS paid to Part B providers for services provided during CYs 2004 through 2006, 77 were appropriate. The 23 remaining payments included net overpayments totaling $117,778, of which $95,736 for 20 payments had not been refunded at the start of our audit.

WPS made the overpayments because its staff inaccurately calculated or entered the payment rates for manually processed claims or because providers reported inaccurate units of service. In addition, the Medicare claim-processing systems did not have sufficient computer edits or manual processing controls in place during CYs 2004 through 2006 to detect and prevent payments for these types of erroneous claims.

Based on the sample results for our 3-year audit period, we estimated that WPS made 402 overpayments totaling $2,057,585 to providers in Illinois, Michigan, Minnesota, and Wisconsin for Part B services.

MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Pub. No. 14, part 2, section 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and 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."

The "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 12, section 20, requires carriers to pay for physician services based on a fee schedule. In addition, chapter 17, section 20, requires carriers to pay for certain drugs based on the CMS published average sales prices.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

WPS made 23 net overpayments totaling $117,778, of which $95,736 for 20 payments had not been refunded at the start of our audit. Providers received these overpayments because WPS staff applied incorrect payment rates when manually processing claims[2] and because providers reported inaccurate units of service. The following examples illustrate the high-dollar overpayments.

- WPS applied an incorrect payment rate for 12 claims for hemophilia drugs and paid providers $326,078 when it should have paid $264,613, resulting in overpayments totaling $61,465.

- A provider billed 70 units of a chemotherapy drug on its claim but delivered only 8 units. As a result, WPS paid the provider $16,865 when it should have paid $1,928, an overpayment of $14,937.

- A provider billed six units of a medication on its claim but delivered only one unit. As a result, WPS paid the provider $12,036 when it should have paid $2,006, an overpayment of $10,030.

- WPS applied an incorrect payment rate for one claim for a beneficiary's cochlear implant and paid the provider $21,500 when the Medicare allowed fee was $12,635, an overpayment of $8,865.

Based on the sample results for our 3-year audit period, we estimated that WPS made 402 overpayments totaling $2,057,585 to providers in Illinois, Michigan, Minnesota, and Wisconsin for Part B services.

CAUSES OF OVERPAYMENTS

WPS attributed the overpayments to staff errors in applying fees and manually calculating payments. WPS also indicated that its postpayment reviews did not include many of the high-dollar medical procedures in our sample. Providers attributed the incorrect claims to clerical errors made by their billing staff.

In addition, during CYs 2004 through 2006, the Medicare Multi-Carrier Claims System and the CMS Common Working File 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 carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[3]

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[2]WPS manually processed many drug claims because its claim-processing system lacked the ability to process units of service in excess of 999.

[3]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.

RECOMMENDATIONS

We recommend that WPS:

- recover the $95,736 in identified overpayments,

- review the 1,647 remaining high-dollar payments with potential overpayments estimated at $1,939,807 ($2,057,585 less $117,778 overpaid) and work with the providers that claimed these services to recover any overpayments,

- consider reviewing high-dollar payments made for services provided after CY 2006 and recover any additional overpayments, and

- improve internal controls related to manual claim processing.

WISCONSIN PHYSICIANS SERVICE COMMENTS

In written comments on our draft report, WPS described corrective actions that it had taken or planned to take to implement our recommendations. WPS's comments are included in their entirety as Appendix C.

APPENDIXES

APPENDIX A

SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population included Wisconsin Physicians Service (WPS) Part B paid claims with payments of $10,000 or more per claim (high-dollar payments) for services provided in calendar years (CY) 2004 through 2006.

SAMPLING FRAME

The sampling frame contained 1,747 high-dollar payments with dates of service in CYs 2004 through 2006. WPS paid Part B providers $35,419,979 for the 1,747 claims. We extracted the paid claim data from the Centers for Medicare & Medicaid Services National Claims History File.

SAMPLE UNIT

The sample unit was a high-dollar payment made to a provider for services rendered to a Medicare beneficiary during the audit period. One claim may have contained multiple lines of service.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

From the 1,747 high-dollar payments, we selected a sample size of 100 with payments totaling $2,051,469.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the payments in our sampling frame. After generating 100 random numbers, we selected the corresponding frame items to create a list of 100 sampled items.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to calculate our estimates. We estimated the total number and dollar amount of the overpayments.

APPENDIX B

SAMPLE RESULTS AND ESTIMATES

Sample Results

Sampling Frame Size	Value of Sampling Frame	Sample Size	Value of Sample Payments	No. of Overpayments	Value of Overpayments
1,747	$35,419,979	100	$2,051,469	23	$117,778

Estimated Overpayments
(Limits calculated for a 90-percent confidence interval)

	Estimated Number of Overpayments	Estimated Value of Overpayments
Point estimate	402	$2,057,585
Lower limit	288	$1,150,772
Upper limit	537	$2,964,398

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

March 6, 2009

Marc Gustafson
Regional Inspector General for Audit Services
Office of Audit Services
233 North Michigan Avenue
Chicago, IL 60601

Re: OIG Blue Book Audit A-05-08-00022 – February 2009

Dear Mr. Gustafson:

This letter is in response to the Draft OIG Blue Book titled "Review of High-Dollar Payments for Services Processed by Wisconsin Physicians Service for the Period January 1, 2004 through December 31, 2006." In your letter, you requested that comments be provided on each of the recommendations.

The OIG reviewed 100 high-dollar Part B claims, of which 77 were appropriate. The results of their review indicated that the remaining 23 payments included overpayments totaling $95,736.

OIG Recommendations:

- *recover the $95,736 in identified overpayments,*
- *review the 1,647 remaining high-dollar payments with potential overpayments estimated at $1,939,807 ($2,057,585 less $117,778 overpaid) and work with the providers that claimed these services to recover any overpayments,*
- *consider reviewing high-dollar payments made for services provided after CY 2006 and recover any additional overpayments, and*
- *improve internal controls related to manual claim processing.*

At this point, WPS has recovered nearly all of the 23 overpayments identified and intends to recoup the remaining ones as soon as feasible. WPS is reviewing the 1,647 remaining high-dollar payments and is taking appropriate action to recover any overpayments. WPS is in the process of reviewing high-dollar payments made for services after CY 2006 for potential overpayment determination and recovery. WPS is also reviewing its claim processes and procedures. Subject to the current limitations within the MCS system, controls will be enhanced, as needed, as a result of that review to reduce the likelihood of similar claim processing issues in the future. One of the controls expected to be implemented in the near future is an automated process, which will reduce the risks involved with manual fee calculations.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

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

Sincerely,

Mark DeFoil
Director, Contract Coordination

cc: Joni Jones, CMS
Sheri Fulcher, OIG