DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

Report Number: A-06-08-00095 January 21, 2009

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 Outpatient Claims Processed by TriSpan Health Services for the Period January 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 (214) 767-8414, or contact Trish Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. P lease refer to report number A-06-08-00095 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE OUTPATIENT CLAIMS PROCESSED BY TRISPAN HEALTH SERVICES FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

January 2009
A-06-08-00095

Office of Inspector General

http://oig.hhs.gov

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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 fiscal intermediary serving more than 1,400 Medicare providers in Mississippi, Louisiana, and Missouri. For calendar year (CY) 2005, TriSpan processed approximately 3.9 million outpatient claims, 11 of which resulted in payments of $50,000 or more (high-dollar payments).

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 11 high-dollar payments that TriSpan made to providers, one was appropriate. TriSpan overpaid providers a total of $782,386 for the remaining 10 claims, which consisted of overstated units of service and incorrect procedure or revenue codes. TriSpan made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2005 to detect billing errors related to units of service or incorrectly billed procedure and revenue codes.

RECOMMENDATIONS

We recommend that TriSpan:

- inform us of the status of the recovery of the $782,386 in overpayments,

- review claims that total between $10,000 and $50,000 and that bill for 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 first and third recommendations and partially agreed with our second recommendation. The full text of TriSpan's comments is included as the Appendix.

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TRISPAN HEALTH SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

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) 2005, fiscal intermediaries processed and paid more than 141 million outpatient claims, 401 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

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 fiscal intermediary serving more than 1,400 Medicare providers in Mississippi, Louisiana, and Missouri. In CY 2005, TriSpan processed approximately 3.9 million outpatient claims, 11 of which were high-dollar payments.

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 11 high-dollar payments for outpatient claims that TriSpan processed during CY 2005. We limited our review of TriSpan'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 a reasonable assurance of the authenticity and accuracy of the data in the 11 claims obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from August through October 2008.

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 11 high-dollar payments that TriSpan made to providers, one was appropriate. TriSpan overpaid providers a total of $782,386 for the remaining 10 claims, which included overstated units of service or incorrect procedure or revenue codes. TriSpan made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2005 to detect billing errors related to units of service or incorrectly billed procedure and revenue codes.

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

The 10 high-dollar claims resulted in the following inappropriate payments:

- For one claim, the pharmacy billed procedure code Q9941 rather than the correct code, Q9942. The provider stated that the pharmacy had not updated its billing system to reflect the drug's new procedure code, which took effect in April 2005. Because the correct code was not used, the system billed for an incorrect number of units. As a result, TriSpan paid the provider $178,405 when it should have paid $1,477, an overpayment of $176,928.

- For one claim, the provider billed procedure code 21470 for 195 units of service although only 1 unit of service had been provided. The provider did not provide an explanation for the billing error.[1] As a result of the error, TriSpan paid the provider $156,899 when it should have paid $5,320, an overpayment of $151,579.

- For two claims, one provider billed procedure code J0256 for 5,000 units per claim rather than 500 units per claim, which was the number of units provided. The provider stated that its billing system contained a coding error for this drug, which caused the billable units to be calculated incorrectly. As a result, TriSpan paid the provider $139,143 when it should have paid $12,276, an overpayment of $126,868.[2]

- For one claim, the provider billed procedure code Q9943 for 1,660 units of service rather than 83 units, which was the amount provided. The provider stated that the billing units for this drug were incorrectly entered in the billing system. As a result, TriSpan paid the provider $79,293 when it should have paid $5,928, an overpayment of $73,365.

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[1]We sent a letter to each provider requesting an explanation of the billing errors, but not all providers submitted a response. We did not attempt to recontact providers that did not explain the errors.

[2]The overpayment amount was rounded to the nearest dollar.

- For one claim, the provider billed procedure code J9265 for 400 units of service rather than 40 units, which was the amount provided. The provider stated that it did not have an edit that monitored unit amounts in its billing system at the time the claim was submitted. As a result, TriSpan paid the provider $62,503 when it should have paid $904, an overpayment of $61,599.

- For one claim, the provider billed procedure code C9205 for 400 units of service rather than 40 units, which was the amount provided. The provider stated that the pharmacy had updated its system to reflect the new procedure code (C9205) for that drug, which took effect in January 2006. However, the pharmacy overrode the system and used the old code because the claim's date of service was prior to the effective date of the new code. The pharmacy did not change the number of units represented by the new code. As a result, TriSpan paid the provider $71,256 when it should have paid $9,869, an overpayment of $61,387.

- For one claim, the provider billed procedure code C9205 for 400 units of service rather than 40 units, which was the amount provided. The provider did not provide an explanation for the billing error. As a result of the error, TriSpan paid the provider $68,219 when it should have paid $9,313, an overpayment of $58,906.

- For one claim, the provider billed procedure code Q0136 for 4,000 units of service rather than 400 units, which was the amount provided. The provider did not provide an explanation for the billing error. As a result of the error, TriSpan paid the provider $50,755 when it should have paid $10,856, an overpayment of $39,899.

- For one claim, the provider stated that the correct charges were billed but that the code for the charges, surgery code 64590, was paid under revenue code 370 rather than revenue code 360. As a result, the payment was calculated differently and TriSpan paid the provider $52,859 when it should have paid $21,005, an overpayment of $31,855.[3]

CAUSES OF OVERPAYMENTS

The providers agreed that overpayments had occurred on the claims and that a refund was due or had already been made. The providers that gave a reason attributed the incorrect claims to their software edit programs, which did not detect and prevent incorrect billing of units of service and incorrect procedure or revenue codes.

In addition, during CY 2005, 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

[3]The overpayment amount was rounded to the nearest dollar.

providers to notify the intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[4]

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:

- inform us of the status of the recovery of the $782,386 in overpayments,
- review claims that total between $10,000 and $50,000 and that bill for 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 AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on our draft report, TriSpan agreed with our first and third recommendations and partially agreed with our second recommendation. In response to the first recommendation, TriSpan stated that it had reviewed the 10 claims and ensured that the providers had adjusted the claims correctly.

In response to the second recommendation, TriSpan said that it plans to obtain a list 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.

In response to the third recommendation, TriSpan said that it plans to review the procedure codes identified in the report and publish frequently asked questions on its Web site. TriSpan also said that it plans to include the information in any applicable presentations or teleconferences it holds for providers during the fiscal year.

We agree with TriSpan's proposal for our second recommendation. The full text of TriSpan's comments is included as the Appendix.

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[4]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

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December 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-06-08-00095 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, 2005." For calendar year (CY) 2005, TriSpan processed approximately 3.9 million outpatient claims, eleven of which resulted in payments of $50,000 or more (high-dollar payments).

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.

Ten of the eleven high-dollar payments that TriSpan made for outpatient services for CY 2005 were not appropriate. The amount of the overpayment totaled $782,386. The providers inappropriately overstated the units of service, or reported incorrect procedure or revenue codes. TriSpan made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2005 to detect billing errors related to units of service.

TriSpan made ten overpayments totaling $782,386 due to the following situations:

- For one claim, the pharmacy billed procedure code Q9941 rather than the correct code Q9942. TriSpan paid the provider $178, 405 when it should have paid $1,477, an overpayment of $176,928.

- For one claim, the provider billed procedure code 21470 for 195 units of service although only 1 unit of service had been provided. TriSpan paid the provider $156,899 when it should have paid $5,320, an overpayment of $151,579.
- For two claims, one provider billed procedure code J0256 for 5,000 units per claim rather than 500 units per claim, which was the number of units provided. TriSpan paid the provider $139,143 when it should have paid $12,276, an overpayment of $126,868.
- For one claim, the provider billed procedure code Q9943 for 1,660 units of service rather than 83 units, which was the amount provided. TriSpan paid the provider $79,293 when it should have paid $5,928, an overpayment of $73,365.
- For one claim, the provider billed procedure code J9265 for 400 units of service rather than 40 units, which was the amount provided. TriSpan paid the provider $62,503 when it should have paid $904, an overpayment of $61,599.
- For one claim, the provider billed procedure code C9205 for 400 units of service rather than 40 units, which was the amount provided. TriSpan paid the provider $71,256 when it should have paid $9,869, an overpayment of $61,387.
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- For one claim, the provider billed procedure code Q0136 for 4,000 units of service rather than 400 units, which was the amount provided. TriSpan paid the provider $50,755 when it should have paid $10,856, an overpayment of $39,899.
- For one claim, the provider stated that the correct charges were billed but that the code for the charges, surgery code 64590, was paid under revenue code 370 rather than revenue code 360. The payment was calculated differently and TriSpan paid the provider $52,859 when it should have paid $21.005, an overpayment of $31,855.

In the OIG draft report, there were three recommendations:

1) inform the OIG of the status of the recover of the $782,386 in overpayments,
2) review claims that total between $10,000 and $50,000 and that bill for the procedure codes identified in this report and correct any claims found in error; and,
3) use the results of this audit in its provider education activities.

In response to the first recommendation, TirSpan has reviewed the ten claims and ensured that the providers adjusted the claims correctly.

In response to the second 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 third recommendation, we will review the procedure codes identified in the report and publish Frequently Asked Questions on our Web site to educate our providers on proper billing as needed. 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 me at (601) 664-4229.

Sincerely,

Jimmy Chaney
Director, Medicare Systems, Claims, and Customer Service
TriSpan Health Services, Inc.