Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

April 22, 2008

Report Number: A-02-07-01043

Mr. Jim Elmore
Regional Vice President, Contract Administration
National Government Services
8115 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 Part B Claims Processed by National Government Services for New York Providers for the Period January 1, 2003, 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, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please contact Brenda Ryan, Audit Manager, at (212) 264-4677 or through e-mail at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-07-01043 in all correspondence.

Sincerely,

Brenda Ryan

for James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nan Foster Reilly, Acting 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 MEDICARE PART B CLAIMS PROCESSED BY NATIONAL GOVERNMENT SERVICES FOR NEW YORK PROVIDERS FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

April 2008
A-02-07-01043

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS 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 providers to bill accurately and to report units of service as the number of times that a service or procedure was performed.

Carriers currently 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.

National Government Services (formerly Empire Medicare Services) is the Medicare Part B carrier for about 48,000 providers in 16 southeastern New York counties. During calendar years (CY) 2003-2005, National Government Services processed more than 123 million Part B claims, 942 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether National Government Services' high-dollar Medicare payments to Part B providers in New York were appropriate.

SUMMARY OF FINDING

Of the 100 high-dollar payments in our statistical sample that National Government Services made to providers, 94 were appropriate. However, National Government Services overpaid providers $39,196 for the remaining six payments. Providers refunded two of the overpayments, totaling $30,075, and partially refunded one overpayment ($7,707 of $7,837), prior to the end of our fieldwork. Four overpayments, totaling $1,414, remained outstanding.

National Government Services made the overpayments because providers incorrectly claimed excessive units of service for four claims, and the carrier inaccurately entered an allowed amount and the number of units of service for two claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003-2005 to detect and prevent payments for these types of erroneous claims.

As a result, for our 3-year audit period, we estimate that National Government Services made 57 overpayments, totaling $369,226, to providers in New York for Part B services.

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $1,414 in overpayments,

- review the remaining 842 high-dollar claims processed during CYs 2003-2005 with potential overpayments estimated at $330,030 ($369,226 less $39,196) and work with the providers that claimed these services to recover any overpayments,

- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005, and

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

NATIONAL GOVERNMENT SERVICES' COMMENTS

In its April 14, 2008, comments on the draft report, National Government Services agreed with our recommendations. National Government Services' comments appear in their entirety in 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 currently 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 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) 2003–2005, providers nationwide submitted approximately 2.4 billion claims to carriers. Of these, 29,022 claims resulted in payments of $10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

National Government Services

National Government Services (formerly Empire Medicare Services) is the Medicare Part B carrier for about 48,000 providers in 16 southeastern New York counties. National Government Services used the Viable Information Processing System (VIPS) Medicare System to process claims until April 30, 2005, and began processing claims using the Medicare Multi-Carrier Claims System in May 2005.[2] National Government Services processed more than 123 million Part B claims during CYs 2003-2005, 942 of which resulted in high-dollar payments.

In January 2007, Empire Medicare Services was one of five companies combined to become National Government Services.[3] The name "National Government Services" used throughout this report refers to the carrier formerly known as Empire Medicare Services.

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

[2] CMS required carriers to transition to the Medicare Multi-Carrier Claims System beginning in 2002. Before that time, carriers could use either the VIPS Medicare System or the Medicare Multi-Carrier Claims System.

[3] AdminaStar Federal; Anthem Health Plans of New Hampshire, Inc.; Associated Hospital Service; Empire Medicare Services; and United Government Services, LLC combined operations and became National Government Services.

"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 are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the "Medicare Program Integrity Manual," Publication 100-08, Transmittal 178, Change Request 5402, 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether National Government Services' high-dollar Medicare payments to Part B providers in New York were appropriate.

Scope

We reviewed a statistical sample of 100 high-dollar payments, totaling $1,250,974, from the 942 high-dollar payments, totaling $11,720,424, that National Government Services processed during CYs 2003-2005.

We limited our review of National Government Services' 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 June to August 2007.

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;
- selected a simple random sample of 100 payments from the universe of 942 high-dollar payments processed by National Government Services during CYs 2003-2005, as detailed in Appendix A;
- reviewed available Common Working File claims histories for each of the 100 sample items to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;

- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine if the initial claims were overpayments;

- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly for our 100 sample claims;

- coordinated our claims review, including the calculation of any overpayments, with National Government Services; and

- used attribute and variable appraisal programs to estimate the number and dollar impact of the overpayments in the total population of 942 high-dollar payments.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the 100 high-dollar payments in our statistical sample that National Government Services made to providers, 94 were appropriate. However, National Government Services overpaid providers $39,196 for the remaining six payments. Providers refunded two of the overpayments, totaling $30,075, and partially refunded one overpayment ($7,707 of $7,837), prior to the end of our fieldwork. Four overpayments, totaling $1,414, remained outstanding.

National Government Services made the overpayments because providers incorrectly claimed excessive units of service for four claims, and the carrier inaccurately entered an allowed amount and the number of units of service for two claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–2005 to detect and prevent payments for these types of erroneous claims.

As a result, for our 3-year audit period, we estimate that National Government Services made 57 overpayments, totaling $369,226, to providers in New York for Part B services. Details of our sample results and projections are shown in Appendix B.

MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Publication 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 . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

For four of the six overpayments, totaling $31,294, providers billed for excessive units of service:

- One provider billed 56 units of service (doses of an intravenous lymphoma drug) for 6 units delivered. The provider stated that it had miscalculated the dosage administered. As a result, National Government Services paid the provider $22,661 when it should have paid $2,616, an overpayment of $20,045. The provider refunded the overpayment during our fieldwork.

- One provider billed six units of service (doses of a chemotherapy drug) for one unit delivered. The provider stated that it had miscalculated the dosage administered. As a result, National Government Services paid the provider $12,057 when it should have paid $2,027, an overpayment of $10,030. The provider refunded the overpayment during our fieldwork.

- One provider billed 406 units of service (doses of an enzyme replacement drug) for 206 units delivered. The provider stated that it had miscalculated the dosage administered. As a result, National Government Services paid the provider $10,627 when it should have paid $10,002, an overpayment of $625. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

- One provider billed 805 units of service (doses of an enzyme replacement drug) for 605 units delivered. The provider stated that is had miscalculated the dosage administered. As a result, National Government Services paid the provider $17,375 when it should have paid $16,781, an overpayment of $594. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

For the remaining two overpayments, totaling $7,902, National Government Services' reimbursement staff made clerical errors that resulted in overpayments:

- The carrier initially paid a provider $10,105 for a claim for which it should have paid $2,268. The carrier entered an incorrect allowed amount, resulting in a $7,837 overpayment. Prior to our audit, the provider had refunded $7,707 of the overpayment but had not refunded the remaining $130.

- The carrier entered 444 units of service (doses of an enzyme replacement drug) for 404 units billed. The carrier stated that due to a keying error, it processed and paid for 444 units of service. As a result, National Government Services paid the provider $13,265 when it should have paid $13,200, an overpayment of $65. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

Providers attributed the incorrect claims to clerical errors made by their billing staffs, and the carrier attributed its incorrect claims to clerical errors made by its reimbursement staff. In addition, during CYs 2003-2005, the VIPS Medicare System, the Medicare Multi-Carrier Claims System and the Common Working File did not have sufficient prepayment controls to detect and

prevent inappropriate payments resulting from these types of erroneous claims. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[4]

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $1,414 in overpayments,

- review the remaining 842 high-dollar claims processed during CYs 2003–2005 with potential overpayments estimated at $330,030 ($369,226 less $39,196) and work with the providers that claimed these services to recover any overpayments,

- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005, and

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

NATIONAL GOVERNMENT SERVICES' COMMENTS

In its April 14, 2008, comments on the draft report, National Government Services agreed with our recommendations. National Government Services' comments appear in their entirety in Appendix C.

[4]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.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether National Government Services' high-dollar Medicare payments to Part B providers in New York were appropriate.

POPULATION

The population was all Part B paid claims with service dates in calendar years 2003 through 2005 for which National Government Service paid providers $10,000 or more.

SAMPLING FRAME

The sampling frame was an Access file containing 942 Part B paid claims with service dates in calendar years 2003 through 2005 for which National Government Services paid a provider $10,000 or more. The total reimbursement for the 942 Part B paid claims was $11,720,424. The paid claims data was extracted from the Centers for Medicare & Medicaid Services National Claims History File.

SAMPLE UNIT

The sample unit was a Part B claim paid to a provider for services rendered to a Medicare beneficiary during the audit period.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample size of 100 high-dollar Part B claims.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services (OAS) Statistical Sampling software, RAT-STATS 2007, version 1. We used the random number generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the claims in our sampling frame and selected the sequential numbers that correlated to the random numbers. We then created a list of 100 sampled items.

CHARACTERISTICS TO BE MEASURED

We based our determination of whether each sampled high-dollar payment was appropriate on Federal regulations and guidance. Specifically, if at least one of the following characteristics was met, we considered the payment under review inappropriate:

- The dosage or the number of units of service was incorrectly billed.
- The provider indicated that the procedure billed was not performed or that the procedure code billed did not accurately represent the service(s) rendered.
- The unit payment amount exceeded the unit allowed amount on the Medicare fee schedule.

ESTIMATION METHODOLOGY

We used both the OAS attribute and variable appraisal programs in RAT-STATS to appraise the sample results.

We used the attribute appraisal program to estimate the total number of high-dollar payments that were inappropriate, and the variable appraisal program to estimate the dollar impact of the inappropriate payments.

SAMPLE RESULTS AND PROJECTIONS

The results of our review of the 100 high-dollar Part B payments were as follows:

Sample Details and Results

No. Payments in Universe	Value of Universe	Sample Size	Value of Sample Payments	No. of Overpayments	Value of Overpayments
942	$11,720,424	100	$1,250,974	6	$39,196

Projection of Sample Results
Precision at the 90-Percent Confidence Level

	Attribute Appraisal	Variable Appraisal
Midpoint	57	$369,226
Lower Limit	27	20,931
Upper Limit	105	717,522

National Government Services

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April 14, 2008

Mr. James P. Edert
Regional Inspector General for Audit Services
Office of Inspector General, Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

RE: Response to Draft Report Number A-02-07-01043

Dear Mr. Edert:

This letter is in response to the above referenced draft report entitled "Review of High Dollar Payments for Medicare Part B Claims Processed by National Government Services for New York Providers for the Period January 1, 2003 through December 31, 2005."

We agree with the audit recommendations noted in the draft report. We have already recovered the $1,414 of overpayments identified in the recommendations. We will also review the remaining 842 high dollar claims processed during calendar years 2003 – 2005 upon receipt of that data and will recover any overpayments in accordance with the Centers for Medicare & Medicaid Services (CMS) Internet Only Manual (IOMs) instructions, unless directed otherwise by CMS. In addition, we will provide further outreach and education to providers on the issues identified in the report.

We will also identify and recover any additional overpayments made for high-dollar Part B claims paid after calendar year 2005 and prior to the medically unlikely edits being implemented in January 2007.

Thank you for the opportunity to respond to the draft report. If you have any additional questions, please feel free to contact Cheryl Leissring, Claims Director, at 414-459-5884.

Sincerely,

Christine Beard

Christine Beard
Regional Vice President, Claims and Operations

cc: Cheryl Leissring, Claims Director

CMS
CENTERS for MEDICARE & MEDICAID SERVICES