



Office of Audit Services
John F. Kennedy Federal Building
Boston, MA 02203

MAR 10 2003

CIN: A-01-02-00516

Ms. Sally T. Wood
Vice President, Program Management
United Government Services, LLC
401 West Michigan Street
Milwaukee, Wisconsin 53203-2804

Dear Ms. Wood:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled, "Review of Potentially Excessive Medicare Payments-United Government Services." A copy of this report will be forwarded to the action official named below for her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5).

To facilitate identification, please refer to Common Identification Number A-01-02-00516 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in cursive script that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. David Dupre
Regional Administrator – Region 5
Centers for Medicare and Medicaid Services
Suite 600
233 N. Michigan Avenue
Chicago, Illinois 60601

cc: Ms. Cheryl Leissring
Director of Internal Compliance, UGS

Ms. Janet Mandel
Manager of Benefit Integrity, TrustSolutions, LLC

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF POTENTIALLY
EXCESSIVE MEDICARE PAYMENTS
UNITED GOVERNMENT SERVICES**



JANET REHNQUIST
Inspector General

MARCH 2003
A-01-02-00516

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:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

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The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees state Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.



MAR 10 2003

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

CIN: A-01-02-00516

Sally T. Wood
Vice President, Program Management
United Government Services, LLC
401 W. Michigan Street
Milwaukee, Wisconsin 53203-2804

Dear Ms. Wood:

The purpose of this letter is to report the results of our review of potentially excessive Medicare payments made to institutional providers for outpatient services during Calendar Year (CY) 2000. Our review at United Government Services (UGS) is part of a nationwide effort being performed at selected Medicare Fiscal Intermediaries (FI).

Based on a computer application, we identified 13 outpatient claims reimbursed by UGS where the number of units or services billed appeared to be excessive. Our analysis showed that provider-billing errors on six renal dialysis facility claims resulted in incorrect payments amounting to \$386,577. For example, one provider incorrectly billed 9.9 million units for the drug *Epogen* (EPO), and was paid over \$80,000. We also identified seven outpatient hospital claims submitted by one provider where the pharmacy charges totaled over \$ 1.3 million. These claims are currently under review by TrustSolutions, LLC.

It appears that the payments in these 13 claims were isolated and does not necessarily indicate a material weakness. However, it does illustrate that the Medicare program remains vulnerable to making excessive payments.

We are recommending that UGS consider improving edits to identify excessive Medicare payments, resolve the reasonableness of the pharmacy charges for the seven outpatient claims, and recover the amount of incorrect payments for all claims. UGS concurred with our recommendations and plans to take steps to develop a procedure to improve edit effectiveness.

BACKGROUND

We initially brought the issue of excessive payments to the attention of the Centers for Medicare and Medicaid Services (CMS) in our report entitled *Review of Potentially Excessive Medicare Payments for Outpatient Services (A-01-00-00502)*, dated May 16, 2001. We reported that simple clerical billing errors on 13 outpatient claims generated \$12 million in excessive Medicare payments to institutional providers. Our current review is a follow up on the prior issues we identified. UGS is one of four fiscal intermediaries we have selected for the follow up review.

LAWS AND REGULATIONS

Title XVIII of the Social Security Amendments of 1965, the Medicare legislation, established a health insurance program for aged persons. Under sections 1816(a) and 1842 (a) of the Social Security Act, public or private organizations and agencies may participate in the administration of the Medicare program. The FIs' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Intermediary Manual section 3700 states:

"It is essential that you [the FI] maintain adequate internal controls over Title XVIII automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

The FIs currently use two standard systems to process outpatient claims – the Fiscal Intermediary Standard System and the Arkansas Part A Standard System. In addition, the Common Working File (CWF) can detect improper payments when processing claims for pre-payment validation.

Claims for outpatient services originate at the provider. Hospital Manual section 462 states:

"In order to be paid correctly and promptly, a bill must be completed accurately."

OBJECTIVES, SCOPE AND METHODOLOGY

Our review was made in accordance with generally accepted government auditing standards. The objective of our review is to identify potentially excessive Medicare payments made to institutional providers for outpatient services during Calendar Year (CY) 2000.

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- utilized CMS' National Claims History file to develop frequency distributions of claim paid amounts for outpatient claims paid during CY 2000;
- used the above frequency distributions to identify outpatient claims that had Medicare claim paid amounts equaling or exceeding \$50,000;
- reviewed available CWF on-line claim histories for these claims to determine if the claims had been canceled and superseded with revised claims; and
- contacted UGS Medicare Benefit Integrity personnel to advise them about our review and its objective discuss and obtain information for selected claims. We requested information about outpatient claims with questionable line item charge amounts.

On December 5, 2002, UGS responded to our requests for information. We conducted our review at the Regional Office of Inspector General, Office of Audit Services in Boston, Massachusetts from May 2002 through January 2003. On February 28, 2003, UGS responded to our draft report (See Appendix A).

FINDINGS AND RECOMMENDATIONS

Based on a computer application, we identified 13 outpatient claims where the number of units or services billed appeared to be excessive. Our analysis, to date, shows that provider billing errors on six dialysis facility claims have resulted in significant payment errors. As illustrated below, one provider incorrectly billed 9.9 million units of EPO for one beneficiary during the month. This generated payment of over \$80,000.

Claim#	FromDt	ThruDt	Line Charge	EPO Units Billed	Amt Paid
1	10/3/00	10/31/00	\$87,000	8,700,000	\$70,959.13
2	12/2/00	12/30/00	\$62,000	6,200,000	\$50,831.36
3	9/1/00	9/29/00	\$80,000	8,000,000	\$65,231.36
4	9/1/00	9/29/00	\$80,500	8,050,000	\$65,892.86
5	9/1/00	9/29/00	\$65,000	6,500,000	\$53,231.36
6	10/2/00	10/30/00	\$99,000	9,900,000	<u>\$80,431.36</u>
Total Dollars subject to recovery action					<u>\$386,577.43</u>

Further discussion with UGS disclosed that the payment system does not have edits in place to identify claims with a high number of EPO units being billed. We commend UGS staff for taking corrective action to initiate recovery action for the claims in question.

We also identified seven outpatient claims submitted by one provider where the monthly pharmacy charges for one beneficiary averaged over \$184,000 for each claim in question. Total pharmacy charges for these claims amount to over \$1.3 million. Final resolution of these claims is currently under review by TrustSolutions, LLC.

It appears that the payments for these 13 claims were isolated and does not necessarily indicate a material weakness. However, it does illustrate that the Medicare program remains vulnerable to making excessive payments.

RECOMMENDATIONS

We are recommending that UGS consider improving edits to identify excessive Medicare payments, resolve the reasonableness of the pharmacy charges for the seven outpatient claims, and recover the amount of incorrect payments for all claims.

UGS RESPONSE

UGS concurred with our recommendations and plans to take steps to develop a procedure to improve edit effectiveness. (See Appendix A).

To facilitate identification, please refer to Common Identification Number A-01-02-00516 in all correspondence relating to this report.

Sincerely yours,



Michael J. Armstrong
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. David Dupre
Regional Administrator – Region V
Centers for Medicare and Medicaid Services
Suite 600
233 N. Michigan Avenue
Chicago, Illinois 60601

cc: Ms. Cheryl Leissring
Director of Internal Compliance, UGS

Ms. Janet Mandel
Manager of Benefit Integrity, TrustSolutions, LLC

APPENDIX

SANDY COSTON, CPA
CHAIRMAN AND PRESIDENT

February 28, 2003

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Inspector General
John F. Kennedy Federal Building
Boston, MA 02203

Dear Mr. Armstrong:

United Government Services, LLC (UGS) appreciates the opportunity to respond to the OIG draft report. "Review of Potentially Excessive Medicare Payments for Outpatient Services, A-01-02-00516".

UGS agrees that the payments for the 13 claims were isolated and do not necessarily indicate a material weakness. The six EPO claims reviewed have already been adjusted by TrustSolutions staff and dollars recovered in part with unit corrections or in full when requested medical records were not received. The remaining seven outpatient claims are still under review by TrustSolutions staff and recoveries will be made as deemed necessary.

UGS agrees with the recommendation to improve edit effectiveness and has, prior to this report, identified this internally as a concern and generated a post payment report to identify claims for review. UGS will develop a procedure as follows that improves edit effectiveness:

1. Develop specific dollar limit thresholds for all bill types.
2. Utilize a specific reason code to pend claims that meet the threshold and the Claims staff will return to provider for verification that the information billed is correct. Once verified and the claim still exceeds the parameter, Claims staff will refer to Medical Review.
3. Medical Review will conduct a routine review, and if necessary, request records. Consultation, after receipt of the records, may be required with the Contractor Medical Director (CMP).

Questionable Inpatient claims will be referred to the designated Quality Improvement Organization (QIO) for follow up.

All other bill types will be processed, if determined medically reasonable and necessary. If not considered medically reasonable and necessary, and a pattern is established, appropriate education will take place. If the trend continues, referral will be made to Benefit Integrity (i.e. TrustSolutions).

4. In addition, Medical Review will develop a procedure with its Data/Statistics Unit to evaluate these types of services that fall outside of the Medical Review Progressive Corrective Action (PCA) process and report the results separately to CMS.

Please be advised that contractors were notified via ABO2100 that prepay review of Epogen for dialysis claims is prohibited.

Thank you for the opportunity to respond to the draft report. If you have any questions or need additional information, please feel free to contact me at 414-226-5588 or Cheryl Leissring at 414-226-5884.

Sincerely,

A handwritten signature in cursive script that reads "Sandy Coston".

Copy: Sally Wood, UGS
Steve Holubowicz, UGS
Pat Coleman, UGS
Barb Hensley, UGS
Cheryl Leissring, UGS
Dave Strzyzewski, UGS
Janet Mandel, TrustSolutions