



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

January 4, 2008

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

Report Number: A-02-07-01045

Mr. James Brady
Director, Medicare Operations
Group Health Incorporated
25 Broadway
New York, New York 10004

Dear Mr. Brady:

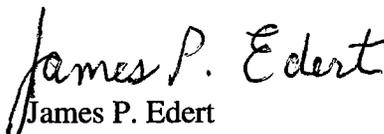
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Medicare Part B Claims Processed by Group Health Incorporated for the Period January 1, 2003, Through December 31, 2005." We will forward a 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) 246-4677 or through e-mail at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-07-01045 in all correspondence.

Sincerely,


James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Tom Lenz, 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
GROUP HEALTH INCORPORATED
FOR THE PERIOD
JANUARY 1, 2003, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

January 2008
A-02-07-01045

Office of Inspector General

<http://oig.hhs.gov>

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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. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

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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 are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

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.

Group Health Incorporated (GHI) is the Medicare Part B carrier for about 11,000 providers in Queens County, New York. During calendar years (CY) 2003–2005, GHI processed more than 11 million Part B claims, 14 of which resulted in payments of \$10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether GHI's high-dollar Medicare payments to Part B providers were appropriate.

SUMMARY OF FINDING

Eleven of the fourteen high-dollar payments that GHI made to providers were appropriate. However, GHI overpaid providers \$84,092 for the remaining three payments. Providers refunded two of the overpayments, totaling \$69,394, prior to our fieldwork. One overpayment of \$14,698 remained outstanding.

GHI made the overpayments because the three providers incorrectly claimed excessive units of service. 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.

RECOMMENDATIONS

We recommend that GHI:

- recover the \$14,698 overpayment and
- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005.

GROUP HEALTH INCORPORATED'S COMMENTS

In its December 19, 2007, comments on the draft report, GHI agreed with our recommendations. GHI's comments are included as the Appendix.

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GROUP HEALTH INCORPORATED’S COMMENTS

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 2.3 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.

Group Health Incorporated

Group Health Incorporated (GHI) is the Medicare Part B carrier for about 11,000 providers in Queens County, New York. GHI used the Viable Information Processing System (VIPS) Medicare System to process claims until August 31, 2005, and began processing new claims using the Medicare Multi-Carrier Claims System in September 2005.² During CYs 2003–2005, GHI processed more than 11 million Part B claims, 14 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 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.

¹The 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.

²CMS 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether GHI's high-dollar Medicare payments to Part B providers were appropriate.

Scope

We reviewed the 14 high-dollar payments, totaling \$215,193, that GHI processed during CYs 2003–2005.

We limited our review of GHI's internal controls to those applicable to the 14 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 at GHI in New York, New York, from April to June 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;
- 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 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 whether 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; and
- coordinated our claim review, including the calculation of any overpayments, with GHI.

We conducted our review in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

Eleven of the fourteen high-dollar payments that GHI made to providers were appropriate. However, GHI overpaid providers \$84,092 for the remaining three payments. Providers refunded two of the overpayments, totaling \$69,394, prior to our fieldwork. One overpayment of \$14,698 remained outstanding.

GHI made the overpayments because the three providers incorrectly claimed excessive units of service. 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.

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 all three overpayments, totaling \$84,092, providers incorrectly billed GHI for excessive units of service:

- One provider billed 780 units of service (office visits) for 1 unit delivered. The provider stated that it had mistakenly entered the diagnosis code in the units-of-service field. As a result, GHI paid the provider \$54,594 when it should have paid \$70, an overpayment of \$54,524. The provider identified and refunded the overpayment prior to our fieldwork.
- One provider billed 58 units of service (arthrography injections) for 1 unit delivered. The provider stated that it had mistakenly entered the modifier code in the units-of-service field. As a result, GHI paid the provider \$16,193 when it should have paid \$1,323, an overpayment of \$14,870. The provider identified and refunded the overpayment prior to our fieldwork.
- One provider billed 48 units of service (doses of a chemotherapy drug) for 5 units delivered. The provider stated that it had miscalculated the doses administered. As a result, GHI paid the provider \$16,407 when it should have paid \$1,709, an overpayment of \$14,698. 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. In addition, during CYs 2003–2005, the VIPS Medicare System, 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

RECOMMENDATIONS

We recommend that GHI:

- recover the \$14,698 overpayment and
- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005.

GROUP HEALTH INCORPORATED’S COMMENTS

In its December 19, 2007, comments on the draft report, GHI agreed with our recommendations. GHI’s comments are included as the Appendix.

³The 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.

APPENDIX



*MEDICARE
Part B Carrier*

December 19, 2007

Mr. James P. Edert
Office of Inspector General
Department of Health and Human Services
26 Federal Plaza
New York, NY 10278

Re: A-02-07-0145

Dear Mr. Edert:

We have reviewed the above captioned report and agree with the recommendations provided. Below is the status of actions taken:

- We have completed the recovery of the \$14,968 overpayment identified during the review.
- We have initiated a review of services billed in excess of \$10,000 for CY2005 and later
- We have developed an additional MCS Audit to preclude payment of services in excess of \$10,000 without manual review.

We have no additional comments, and appreciate your efforts in assisting us to protect the Medicare trust fund.

Sincerely,

A handwritten signature in black ink, appearing to read "Jim Brady".

Jim Brady
Director
Medicare Operations

*Group Health Incorporated
25 Broadway, New York, NY 10004-1010
A CMS Contracted Carrier
www.ghimedicare.com*