



DEC - 8 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services

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

SUBJECT: Review of High-Dollar Payments for Outpatient Services Processed by First Coast Service Options, Inc., for the Period January 1, 2004, Through December 31, 2005 (A-04-08-06008)

Attached is an advance copy of our final report on high-dollar payments for outpatient services processed by First Coast Service Options, Inc. (First Coast), for the period January 1, 2004, through December 31, 2005. These claims were submitted by providers in Florida. We will issue this report to First Coast within 5 business days. This audit was part of a nationwide review of excessive payments for outpatient services of \$50,000 or more (high-dollar payments).

Our objective was to determine whether high-dollar Medicare payments that First Coast made to hospitals for outpatient services were appropriate.

Of the 40 high-dollar payments that First Coast made for outpatient services for calendar years (CY) 2004 and 2005, 23 were appropriate. The remaining 17 payments included overpayments totaling \$1,498,529, which the hospitals had not refunded by the beginning of our audit. The hospitals received these overpayments by billing excessive units of service. First Coast made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2004 and 2005 to detect and prevent the overpayments.

We recommend that First Coast recover the \$1,498,529 in identified overpayments.

In written comments on our draft report, First Coast stated that it had adjusted the identified outpatient claims and initiated its standard overpayment recovery procedures to recover the overpayments.

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

Page 2 – Kerry Weems

or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through e-mail at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-08-06008.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

DEC 12 2008

Report Number: A-04-08-06008

Ms. Sandy Coston
President
First Coast Service Options, Inc.
532 Riverside Avenue, 20 T
Jacksonville, Florida 32202

Dear Ms. Coston:

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 Outpatient Services Processed by First Coast Service Options, Inc., for the Period January 1, 2004, 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, or contact Mary Ann Moreno, Audit Manager, at (404) 562-7770 or through e-mail at Mary.Moreno@oig.hhs.gov. Please refer to report number A-04-08-06008 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "Peter J. Barbera".

Peter J. Barbera
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 OUTPATIENT
SERVICES PROCESSED BY FIRST
COAST SERVICE OPTIONS, INC.,
FOR THE PERIOD
JANUARY 1, 2004, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

December 2008
A-04-08-06008

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 Office of Audit Services (OAS) provides 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. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

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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 for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General 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).

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 (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

Medicare guidance requires hospitals to claim outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of services as the number of times that a service or procedure was performed.

During our audit period (calendar years (CY) 2004 and 2005), First Coast Service Options, Inc. (First Coast), was the fiscal intermediary in Florida. First Coast processed 6.9 million outpatient claims during this period, 40 of which resulted in payments of \$50,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that First Coast made to hospitals for outpatient services were appropriate.

SUMMARY OF FINDING

Of the 40 high-dollar payments that First Coast made for outpatient services for CYs 2004 and 2005, 23 were appropriate. The remaining 17 payments included overpayments totaling \$1,498,529, which the hospitals had not refunded by the beginning of our audit. The hospitals received these overpayments by billing excessive units of service. First Coast made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during CYs 2004 and 2005 to detect and prevent the overpayments.

RECOMMENDATION

We recommend that First Coast recover the \$1,498,529 in identified overpayments.

FIRST COAST SERVICE OPTIONS COMMENTS

In written comments on our draft report, First Coast stated that it had adjusted the identified outpatient claims and initiated its standard overpayment recovery procedures to recover the overpayments. The complete text of First Coast's comments is included as the Appendix.

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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 hospitals' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validations.

In calendar years (CY) 2004 and 2005, fiscal intermediaries processed and paid approximately 278 million outpatient claims, 989 of which resulted in payments of \$50,000 or more (high-dollar payments).

Claims for Outpatient Services

Medicare guidance requires hospitals to submit accurate claims for outpatient services. Hospitals should use the appropriate Healthcare Common Procedure Coding System codes and report units of service as the number of times that a service or procedure was performed.

First Coast Service Options, Inc.

During our audit period (CYs 2004 and 2005), First Coast Service Options, Inc. (First Coast), was the fiscal intermediary in Florida. First Coast processed approximately 6.9 million outpatient claims during this period, 40 of which resulted in high-dollar payments totaling \$3.3 million.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that First Coast made to hospitals for outpatient services were appropriate.

Scope

We reviewed the 40 high-dollar payments for outpatient claims that First Coast processed during CYs 2004 and 2005. We limited our review of First Coast's internal controls to those applicable to the 40 high-dollar 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 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 fieldwork from April 2007 through May 2008. Our fieldwork included contacting First Coast, located in Jacksonville, Florida, and the hospitals that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient claims with high-dollar payments;
- reviewed available CWF claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims and whether payments remained outstanding at the time of our fieldwork;
- 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
- validated with First Coast that partial overpayments occurred and refunds were appropriate.

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 RECOMMENDATION

Of the 40 high-dollar payments that First Coast made for outpatient services for CYs 2004 and 2005, 23 were appropriate. The remaining 17 payments included overpayments totaling \$1,498,529, which the hospitals had not refunded by the beginning of our audit. The hospitals received these overpayments by billing excessive units of service. First Coast made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during CYs 2004 and 2005 to detect and prevent the overpayments.

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 Healthcare Common Procedure Coding System codes. CMS's "Medicare Claims Processing Manual," Publication No. 100-04, Chapter 4, section 20.4, states: "The definition 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 this manual states: "In order 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

Hospitals reported excessive units of service on 17 claims, resulting in overpayments totaling \$1,498,529. The following examples illustrate the excessive units of service:

- A hospital billed three claims with a total of 72 units of service for 3 units delivered because of a clerical error. The hospital's automated compliance software identified the error and notified the billing office. However, the billing clerks did not make the appropriate corrections. As a result, First Coast paid the hospital \$324,416 when it should have paid \$19,545, an overpayment of \$304,871.
- A hospital billed 300 units of service rather than the 30 units delivered because of a software multiplication error that occurred when the hospital pharmacy's electronic billing system changed. As a result, First Coast paid the hospital \$50,057 when it should have paid \$4,422, an overpayment of \$45,635.

The hospitals attributed the incorrect claims to clerical errors or to pharmacy and billing systems that could not detect and prevent the errors. The hospitals agreed that excessive units were billed and that overpayments occurred.

CAUSES OF OVERPAYMENTS

During CYs 2004 and 2005, First Coast made the incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.¹

¹The fiscal intermediary sends an "Explanation of Medicare Benefits" notice to the beneficiary after the hospital 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.

FISCAL INTERMEDIARY PREPAYMENT EDIT

On January 3, 2006, after 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.

RECOMMENDATION

We recommend that First Coast recover the \$1,498,529 in identified overpayments.

FIRST COAST SERVICE OPTIONS COMMENTS

In its October 8, 2008, written comments on our draft report, First Coast stated that it had adjusted the identified outpatient claims and initiated its standard overpayment recovery procedures to recover the overpayments. The complete text of First Coast's comments is included as the Appendix.

APPENDIX



Sandy Coston
CEO & President
First Coast Service Options, Inc.
Sandy.Coston@fcsso.com

October 8, 2008

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

Reference: A-04-08-06008

Dear Mr. Barbera:

We received the U.S. Department of Health & Human Services, Office of Inspector General draft report entitled, "Review of High-Dollar Payments for Outpatient Services Processed by First Coast Service Options, Inc." for the period January 1, 2004 through December 31, 2005. We appreciate the opportunity to review and provide comments prior to release of the final report.

In the draft report, you recommended:

Recommendation:

- Recover the \$1,498,529 in identified overpayments.

Response:

First Coast Service Options, Inc. has adjusted the identified outpatient claims and initiated its standard overpayment recovery procedures to recover the overpayments.

Again, we appreciate the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding our response, please contact Mr. Gregory W. England at (904) 791-8364.

Sincerely,


Sandy Coston

cc: Greg England