



Office of Audit Services
Region I
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February 9, 2009

Report Number: A-01-08-00514

Ms. Anne Bockhoff Dalton
Vice President/Regional Manager
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, Massachusetts 02043

Dear Ms. Bockhoff Dalton:

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 NHIC, Corp., for Calendar Years 2004–2006." 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 Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. 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 Leah Scott, Audit Manager, at (617) 565-2679 or through e-mail at Leah.Scott@oig.hhs.gov. Please refer to report number A-01-08-00514 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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 MEDICARE
PART B CLAIMS PROCESSED BY
NHIC, CORP., FOR
CALENDAR YEARS 2004–2006**



Daniel R. Levinson
Inspector General

February 2009
A-01-08-00514

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 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.

NHIC, Corp. (NHIC), is the Medicare Part B carrier for about 53,000 providers in Maine, Massachusetts, New Hampshire, and Vermont. During calendar years (CY) 2004–2006, NHIC processed more than 80 million Part B claims, 563 of which resulted in payments of \$10,000 or more (high-dollar payments). Most of the high-dollar payments (457) were for blood clotting factor drugs.

OBJECTIVE

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

SUMMARY OF FINDING

Most of the high-dollar Medicare payments that NHIC made to Part B providers were appropriate. Specifically, in our sample of 100 of the 457 claims for blood clotting factor drugs that resulted in high-dollar payments, 81 claims were paid appropriately. However, NHIC overpaid providers \$19,954 for 11 claims and underpaid providers \$2,960 for 8 claims, resulting in net overpayments of \$16,994. Providers refunded four overpayments totaling \$3,621 before our fieldwork and three overpayments totaling \$11,199 during our fieldwork. Net overpayments totaling \$2,175 remained outstanding. For our 3-year audit period, we estimate that NHIC made overpayments totaling \$77,664 to providers in Maine, Massachusetts, New Hampshire, and Vermont for blood clotting factor drugs. These incorrect payments occurred because NHIC staff entered inaccurate Medicare-allowed amounts when processing the claims.

Of 31 judgmentally selected claims with high-dollar payments that NHIC made to providers for other Part B services, 16 were appropriate. However, NHIC overpaid providers \$251,514 for the remaining 15 claims. Providers refunded four overpayments totaling \$100,153 before our fieldwork and four overpayments totaling \$72,865 during our fieldwork. Net overpayments totaling \$78,496 remained outstanding. NHIC made these overpayments because the providers claimed excessive units of service, billed for incorrect Healthcare Common Procedure Coding System codes, or billed for services not provided. In addition, the Medicare claim processing

systems did not have sufficient edits in place during CYs 2004–2006 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that NHIC:

- recover \$2,175 in net overpayments for the 100 sampled claims for blood clotting factor drugs and \$78,496 in net overpayments for the judgmentally selected claims for other Part B services;
- review the remaining 357 high-dollar claims for blood clotting factor drugs processed during CYs 2004–2006 with potential overpayments estimated at \$60,670 (\$77,664 less \$16,994) 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 2006; and
- use the results of this audit in its provider education activities.

NHIC, CORP., COMMENTS

In comments on our draft report, NHIC agreed with our finding and recommendations. NHIC's comments are included in their entirety as Appendix C.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Part B Carriers	1
NHIC, Corp.....	1
“Medically Unlikely” Edits	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope.....	2
Methodology	2
FINDING AND RECOMMENDATIONS	3
MEDICARE REQUIREMENTS.....	4
INAPPROPRIATE HIGH-DOLLAR PAYMENTS	4
Blood Clotting Factor Drugs.....	4
Other Part B Services.....	4
RECOMMENDATIONS.....	5
NHIC, CORP. COMMENTS.....	6
 APPENDIXES	
A – SAMPLE DESIGN AND METHODOLOGY	
B – SAMPLE RESULTS AND ESTIMATES	
C – NHIC, CORP. 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

Before 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 (MCS) and CMS's Common Working File (CWF). 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) 2004–2006, providers nationwide submitted approximately 2.4 billion claims to carriers. Of these, 31,576 claims resulted in payments of \$10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

NHIC, Corp.

NHIC, Corp. (NHIC), is the Medicare Part B carrier for about 53,000 providers in Maine, Massachusetts, New Hampshire, and Vermont. During CYs 2004–2006, NHIC processed more than 80 million Part B claims, 563 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 (HCPCS) 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed a simple random sample of 100 claims with high-dollar payments totaling \$2,504,706 from the 457 claims with payments totaling \$11,350,186 for blood clotting factor drugs that NHIC processed during CYs 2004–2006. We also reviewed a judgmental sample of 31 claims with high-dollar payments totaling \$485,227 from the 106 other Part B claims with high dollar payments totaling \$1,416,912 that NHIC processed during CYs 2004–2006.

We limited our review of NHIC's internal controls to those applicable to the 131 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 audit work from February through December 2008. Our audit work included contacting NHIC, headquartered in Chico, California, and the providers who received the high-dollar payments.

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;
- identified from CMS's National Claims History file 563 claims with high-dollar payments and separated the claims into two groups: claims for blood clotting factor drugs (457 claims) and all other Part B claims (106 claims);
- selected a simple random sample of 100 claims from the population of blood clotting factor drug claims (Appendix A);
- analyzed claims for all other Part B services and selected a judgmental sample of 31 claims with a high probability of error;

- reviewed available CWF claims histories for each of the 131 high-dollar claims 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 CWF 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;
- estimated the potential overpayments for the blood clotting factor drug claims (Appendix B); and
- coordinated our claim review with NHIC.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Most of the high-dollar Medicare payments that NHIC made to Part B providers were appropriate. Specifically, in our sample of 100 of the 457 claims for blood clotting factor drugs that resulted in high-dollar payments, 81 claims were paid appropriately. However, NHIC overpaid providers \$19,954 for 11 claims and underpaid providers \$2,960 for 8 claims, resulting in net overpayments of \$16,994. Providers refunded four overpayments totaling \$3,621 before our fieldwork and three overpayments totaling \$11,199 during our fieldwork. Net overpayments totaling \$2,175 remained outstanding. For our 3-year audit period, we estimate that NHIC made overpayments totaling \$77,664 to providers in Maine, Massachusetts, New Hampshire, and Vermont for blood clotting factor drugs. These incorrect payments occurred because NHIC staff entered inaccurate Medicare-allowed amounts when processing the claims.

Of 31 judgmentally selected claims with high-dollar payments that NHIC made to providers for other Part B services, 16 were appropriate. However, NHIC overpaid providers \$251,514 for the remaining 15 claims. Providers refunded four overpayments totaling \$100,153 before our fieldwork and four overpayments totaling \$72,865 during our fieldwork. Net overpayments totaling \$78,496 remained outstanding. NHIC made these overpayments because the providers claimed excessive units of service, billed for incorrect HCPCS codes, or billed for services not provided. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004–2006 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

Blood Clotting Factor Drugs

Of our sample of 100 of the 457 claims for blood clotting factor drugs that resulted in high dollar payments, 19 were paid inappropriately. For these 19 claims, NHIC staff made errors resulting in both overpayments (11 claims totaling \$19,954) and underpayments (8 claims totaling \$2,960). The providers identified and refunded \$3,621 for four claims before our fieldwork and \$11,199 for three claims during our fieldwork. Net overpayments totaling \$2,175 remained outstanding. For our 3-year audit period, we estimate that NHIC made overpayments totaling \$77,664 to providers in Maine, Massachusetts, New Hampshire, and Vermont for blood clotting factor drugs (Appendix B).

The following examples illustrate the types of errors that we found:

- NHIC reimbursed a medical supplier \$1.200 per unit of a drug when it should have reimbursed the provider \$1.056 per unit. As a result, NHIC paid the provider \$31,659 when it should have paid \$27,853, an overpayment of \$3,806.
- NHIC reimbursed a medical supplier \$1.060 per unit of a drug when it should have reimbursed the provider \$1.064 per unit. As a result, NHIC paid the provider \$18,319 when it should have paid \$18,389, an underpayment of \$70.

These incorrect payments occurred because NHIC staff entered inaccurate Medicare-allowed amounts when processing the claims.

Other Part B Services

Of 31 judgmentally selected claims with high-dollar payments that NHIC made to providers for other Part B services, 15 claims were paid inappropriately, resulting in overpayments totaling \$251,514. Providers refunded four overpayments totaling \$100,153 before our fieldwork and four overpayments totaling \$72,865 during our fieldwork. Net overpayments totaling \$78,496 remained outstanding. These overpayments for other Part B services resulted from providers billing for excessive units of service, billing incorrect HCPCS codes, or billing for services not provided.

The following examples illustrate the types of errors that we found:

- One physician billed 20 units of pegfilgrastim for 1 unit delivered. As a result, NHIC paid the provider \$33,267 when it should have paid \$1,681, an overpayment of \$31,586.
- One physician billed 120 units of cisplatin for 12 units delivered and billed an incorrect HCPCS code for camptosar administered on the same date of service. As a result, NHIC paid the provider \$29,559 when it should have paid \$484, an overpayment of \$29,075.
- One physician billed 300 units for avastin that the beneficiary did not receive. As a result, NHIC overpaid the provider \$11,942.

Providers attributed the incorrect claims to clerical errors made by their billing and clinical staff. In addition, during CYs 2004–2006, the MCS and the CWF 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 overpayments.²

RECOMMENDATIONS

We recommend that NHIC:

- recover \$2,175 in net overpayments for the 100 sampled claims for blood clotting factor drugs and \$78,496 in net overpayments for the judgmentally selected claims for other Part B services,
- review the remaining 357 high-dollar claims for blood clotting factor drugs processed during CYs 2004–2006 with potential overpayments estimated at \$60,670 (\$77,664 less \$16,994) 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 2006, and
- use the results of this audit in its provider education activities.

NHIC, CORP., COMMENTS

²The 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.

In comments on our draft report, NHIC agreed with our finding and recommendations. NHIC's comments are included in their entirety as Appendix C.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

POPULATION

The population consisted of Part B claims with service dates in calendar years 2004 through 2006 for which NHIC paid a provider \$10,000 or more.

SAMPLING FRAME

The sampling frame was a Microsoft Excel file containing 457 Part B claims totaling \$11,350,186 with service dates in calendar years 2004 through 2006 that contain HCPCS codes of J7188, J7189, J7190, J7192, J7193, J7195, J7198, Q0187, and Q2022 (blood clotting factors) for which NHIC paid a provider \$10,000 or more.

SAMPLE UNIT

The sample unit was a Part B claim paid to a provider for services provided to a Medicare beneficiary during the audit period. One claim may contain multiple lines of service.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100.

SOURCE OF THE RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, statistical software.

METHOD OF SELECTING SAMPLED UNITS

We numbered the sampling frame sequentially from 1 through 457. We then selected 100 random numbers and matched them to the sequential numbers assigned to the claims in the sampling frame.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services, statistical software to estimate the potential overpayments.

SAMPLE RESULTS AND ESTIMATES

Sample Results

Frame Size	Frame Value	Sample Size	Value of Sample	Number of Overpayments and Underpayments	Value of Net Overpayment s
457	\$11,350,186	100	\$2,504,706	19	\$16,994

Estimated Unallowable Payments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$77,664
Lower limit	\$5,249
Upper limit	\$150,079



Phone: (530) 332-1169

January 28, 2009

Michael J. Armstrong
Office of Inspector General
Office of Audit Services
Region 1
John F. Kennedy Federal Building
Boston, MA 02203

Subject: Office of Inspector General's Draft Report, "Review of High- Dollar Payments for Medicare B Claims Processed by NHIC, Corp., for Calendar Years 2004-2006 (A-01-08-00514).

Dear Mr. Armstrong:

We received the U.S Department of Health & Human Services, Office of the Inspector General draft report "Review of High- Dollar Payments for Medicare B Claims Processed by NHIC, Corp., for Calendar Years 2004-2006". We appreciate the opportunity to review and provide comments.

We have reviewed the draft report's recommendations and provide the following responses:

1. Recommendation: *Recover \$2,175 in net overpayments for the 100 sampled claims for blood clotting factor drugs and \$78,496 in net overpayments for the judgmentally selected claims for other Part B services.*

NHIC Response

NHIC has initiated an overpayment recovery project to identify and recover any overpayments not already recovered (\$662.89 - Sampled/ \$76,949.19 – Judgmental).

2. Recommendation: *Review the remaining 357 high-dollar claims for blood clotting factor drugs processed during CYs 2004-2006 with potential overpayments estimated at \$60,670 (\$77,664 less \$16,994) and work with the providers that claimed these services to recover any overpayments.*

NHIC Response

NHIC has initiated identification of high-dollar claims processed during calendar years 2004-2006 and will instruct associated providers to complete a self-audit and refund all identified overpayments.

3. Recommendation: *Consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2006.*

NHIC Response

NHIC has initiated identification of high-dollar claims processed after calendar year 2006 and will instruct associated providers to complete a self-audit and refund all identified overpayments.

NHIC, Corp.

www.medicarenhic.com

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Chico, CA 95928
A CMS CONTRACTOR

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4. Recommendation: *Use the results of this audit in its provider education activities*

NHIC Response

An educational article on the high dollar, blood clotting factor drugs was posted on NHIC's website (http://www.medicarenhic.com/ne_prov/articles/hemophilliaclottingfactors.pdf) in September 2008.

If you have any questions regarding NHIC's corrective actions, please contact me at 530-332-1169 (or at jennifer.otten@eds.com).

Sincerely,

A handwritten signature in black ink that reads "Jennifer Otten". The signature is written in a cursive, flowing style.

Jennifer Otten
Manager, Audit & Controls
NHIC, Corp.

cc: Robert Harrington, NHIC, Corp.