



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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

October 13, 2009

Report Number: A-01-09-00513

Mr. James Elmore
Regional Vice President, Contract Administration
National Government Services, Inc.
8115-8125 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 First Coast Service Options, Inc., 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted 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-01-09-00513 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

cc:

Scott Kimbell

J13 Contract Director

National Government Services, Inc.

Direct Reply to HHS Action Official:

Nanette Foster Reilly, Consortium Administrator

Consortium for Financial Management & Fee for Service Operations (CFMFFSO)

Centers for Medicare & Medicaid Services

601 East 12th Street, Room 235

Kansas City, Missouri 64106

rokcmora@cms.hhs.gov

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR PAYMENTS
FOR MEDICARE PART B CLAIMS
PROCESSED BY
FIRST COAST SERVICE OPTIONS, INC.,
FOR CALENDAR YEARS 2004–2006**



Daniel R. Levinson
Inspector General

October 2009
A-01-09-00513

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.

During calendar years (CY) 2004–2006, First Coast Service Options, Inc. (First Coast), was the Medicare Part B carrier for providers in Connecticut. First Coast processed more than 36 million Part B claims, 193 of which resulted in payments of \$10,000 or more (high-dollar payments).

Beginning August 1, 2008, CMS contracted with National Government Services, Inc. (NGS), to process Connecticut Medicare Part B claims. Because NGS assumed responsibility for ensuring that any inappropriately paid claims for CYs 2004–2006 are corrected, we are issuing our report to NGS.

OBJECTIVE

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

SUMMARY OF FINDING

Of the 193 high-dollar Medicare payments that First Coast made to Part B providers, 90 were appropriate. However, First Coast overpaid providers \$130,561 for 65 claims and underpaid providers \$15,777 for 38 claims, resulting in net overpayments of \$114,783. Before our fieldwork, providers refunded five overpayments totaling \$46,711, and the carrier corrected one underpayment of \$11,741. Providers also refunded two overpayments totaling \$10,019 during our fieldwork. Net overpayments totaling \$69,794 remained outstanding.

These incorrect payments occurred because First Coast staff entered inaccurate Medicare-allowed amounts and billed amounts when manually processing the claims. In addition, 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 NGS:

- recover outstanding net overpayments of \$69,794 identified during our audit,
- 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.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In written comments on our draft report, NGS stated that it had forwarded the draft report to the CMS project officer responsible for the Medicare contract jurisdiction to determine what actions should be taken with respect to our recommendations. NGS's comments are included in their entirety as the Appendix.

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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

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). 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.

First Coast Service Options, Inc.

During CYs 2004–2006, First Coast Service Options, Inc. (First Coast), was the Medicare Part B carrier for providers in Connecticut. First Coast processed more than 36 million Part B claims, 193 of which resulted in high-dollar payments.

National Government Services, Inc.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.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. As a result, CMS contracted with National Government Services, Inc. (NGS), to process Connecticut Medicare Part B claims, beginning August 1, 2008. Because NGS assumed responsibility for ensuring that any inappropriately paid CY 2004–2006 claims are corrected, we are issuing our report to NGS.

“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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether First Coast’s high-dollar Medicare payments to Part B providers were appropriate.

Scope

We reviewed 193 claims with high-dollar payments totaling \$3,979,352 that First Coast processed during CYs 2004–2006.

We limited our review of First Coast’s internal controls to those applicable to the 193 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 June 2009. Our audit work included contacting NGS, headquartered in Indianapolis, Indiana, 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 193 claims with high-dollar payments;

- reviewed available CWF claim histories for each of the 193 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 available 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; and
- coordinated our claim review with NGS.

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 RECOMMENDATIONS

Of the 193 high-dollar Medicare payments that First Coast made to Part B providers, 90 were appropriate. However, First Coast overpaid providers \$130,561 for 65 claims and underpaid providers \$15,777 for 38 claims, resulting in net overpayments of \$114,783. Before our fieldwork, providers refunded five overpayments totaling \$46,711, and the carrier corrected one underpayment of \$11,741. Providers also refunded two overpayments totaling \$10,019 during our fieldwork. Net overpayments totaling \$69,794 remained outstanding.

These incorrect payments occurred because First Coast staff entered inaccurate Medicare-allowed amounts and billed amounts when manually processing the claims. In addition, 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

First Coast incorrectly processed 92 claims, and these errors resulted in incorrect payments to providers. In addition, providers received incorrect payments for 10 claims that providers had billed incorrectly. First Coast also made one incorrect payment for excessive units of service, but we were unable to determine whether the provider billed the claim incorrectly or the carrier processed the claim incorrectly.

Carrier Claims Processing Errors

First Coast incorrectly processed 92 claims. For these 92 claims, First Coast staff made errors resulting in both overpayments (54 claims totaling \$60,061) and underpayments (38 claims totaling \$15,777). A provider identified and refunded \$8,768 for one claim during our fieldwork. Before our fieldwork, one provider received the full payment for a claim that was originally underpaid by \$11,741. Net overpayments totaling \$47,256 remained outstanding.

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

- First Coast reimbursed a medical supplier \$1.000 per unit of a drug when it should have reimbursed the provider \$0.641 per unit. As a result, First Coast paid the provider \$10,048 when it should have paid \$6,441, an overpayment of \$3,607.
- First Coast reimbursed a medical supplier \$1.060 per unit of a drug when it should have reimbursed the provider \$1.063 per unit. As a result, First Coast paid the provider \$25,949 when it should have paid \$26,022, an underpayment of \$73.
- First Coast reimbursed a medical supplier \$11,827 for 8 units of a drug when it should have reimbursed the provider \$23,568 for the 24 units billed. As a result, First Coast underpaid the provider \$11,741.

These incorrect payments occurred because First Coast staff entered inaccurate Medicare-allowed amounts and billed amounts when manually processing the claims.

Provider Billing Errors

First Coast incorrectly paid 10 claims because the provider billed for excessive units of service, used incorrect HCPCS codes, or billed for services not provided. Providers refunded five overpayments totaling \$46,711 before our fieldwork and one overpayment of \$1,251 during our fieldwork. Net overpayments totaling \$22,260 remained outstanding.

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

- One physician billed six units of pegfilgrastim for one unit delivered. As a result, First Coast paid the provider \$12,637 when it should have paid \$2,607, an overpayment of \$10,030.
- One physician billed an incorrect HCPCS code for camptosar. As a result, First Coast overpaid the provider \$9,205.
- One physician billed for chemotherapy administration services that were not provided. As a result, First Coast overpaid the provider \$87.

Providers attributed the incorrect claims to clerical errors made by their billing 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.¹

Other Error

First Coast incorrectly paid one claim for excessive units of service; however, we were unable to determine whether the provider billed the claim incorrectly or the carrier processed the claim incorrectly. An overpayment of \$278 remained outstanding.

RECOMMENDATIONS

We recommend that NGS:

- recover outstanding net overpayments of \$69,794 identified during our audit,
- 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.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS

In written comments on our draft report, NGS stated that it had forwarded the draft report to the CMS project officer responsible for the Medicare contract jurisdiction to determine what actions should be taken with respect to our recommendations. NGS’s comments are included in their entirety as the Appendix.

¹The 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



National Government Services, Inc.
8115 Knue Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

APPENDIX
Medicare

September 16, 2009

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

RE: Report Number A-01-09-00513

Dear Mr. Armstrong;

The following is National Government Service's (NGS) response to the Office of Inspector General (OIG) draft report entitled "Review of High-Dollar Payments for Medicare Part B Claims processed by First Coast Service Options, Inc. (FCSO), for calendar years 2004-2006. As noted in the draft report, on August 1, 2008, the Centers for Medicare and Medicaid Services (CMS) contracted with NGS to process Connecticut Medicare Part B claims that were previously the responsibility of FCSO.

We forwarded the draft report to [REDACTED] CMS [REDACTED]. Her team will determine our next steps related to the following:

- Recovering outstanding overpayments identified during the audit;
- Identifying and recovering any additional overpayments made for high-dollar Part B claims paid after calendar year 2006, and;
- Using the results of the audit in provider education activities

When we receive her response, we will advise you of our next steps.

Sincerely,

A handwritten signature in black ink, appearing to read "Dave Marshall".

Dave Marshall
Staff Vice President, Business Management
National Government Services



Office of Inspector General Note - The deleted text has been redacted because it is personally identifiable information.