



December 19, 2011

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services
Processed by NHIC, Corp., in Jurisdiction 14 for the Period January 1, 2006,
Through June 30, 2009 (A-01-10-00502)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services by NHIC, Corp., in Jurisdiction 14. We will issue this report to NHIC, Corp., within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Michael Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689 or through email at Michael.Armstrong@oig.hhs.gov. Please refer to report number A-01-10-00502.

Attachment



Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

December 21, 2011

Report Number: A-01-10-00502

Ms. Anne Bockhoff-Dalton
Vice President
NHIC, Corp.
75 Sgt. William B. Terry Drive
Hingham, MA 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 Medicare Payments Exceeding Charges for Outpatient Services Processed by NHIC, Corp., in Jurisdiction 14 for the Period January 1, 2006, Through June 30, 2009*. 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 email at Leah.Scott@oig.hhs.gov. Please refer to report number A-01-10-00502 in all correspondence.

Sincerely,

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

Enclosure

cc: Robert Harrington
Jennifer Otten, ASQ-CMQOE

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, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
EXCEEDING CHARGES FOR
OUTPATIENT SERVICES
PROCESSED BY NHIC, CORP.,
IN JURISDICTION 14 FOR
THE PERIOD JANUARY 1, 2006,
THROUGH JUNE 30, 2009**



Daniel R. Levinson
Inspector General

December 2011
A-01-10-00502

Office of Inspector General

<http://oig.hhs.gov>

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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.

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 aged 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 Medicare contractors to process and pay Medicare claims submitted for outpatient services. The Medicare contractors 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 providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered. In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

In November 2008, CMS announced that it had awarded to NHIC, Corp. (NHIC), the Medicare administrative contractor contract for Jurisdiction 14 in five States. During our audit period (January 2006 through June 2009), approximately 145.8 million line items for outpatient services were processed in Jurisdiction 14, of which 1,396 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$500 and (2) 3 or more units of service. (A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges.")

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges that NHIC made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 1,396 selected line items for which NHIC made Medicare payments to providers for outpatient services during our audit period, 559 were correct. Providers refunded overpayments on 81 line items totaling \$561,548 before our fieldwork. The remaining 756 line items were

incorrect and included overpayments totaling \$3,168,213, which the providers had not refunded by the beginning of our audit.

Of the 756 incorrect line items:

- Providers reported incorrect units of service on 514 line items, resulting in overpayments totaling \$2,375,447.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 72 line items, resulting in overpayments totaling \$273,097.
- Providers used HCPCS codes that did not reflect the procedures performed on 116 line items, resulting in overpayments totaling \$271,041.
- Providers billed for unallowable services on 52 line items, resulting in overpayments totaling \$218,872.
- Other errors on two line items resulted in overpayments totaling \$29,756.

The providers attributed the incorrect payments to clerical errors or to systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NHIC made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that NHIC:

- recover the \$3,168,213 in identified overpayments,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

NHIC, CORP., COMMENTS

In written comments on our draft report, NHIC concurred with our recommendations. However, citing limitations within CMS's Part A processing system, NHIC stated that our second recommendation to implement system edits would "require additional clarification and discussion." NHIC's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We encourage NHIC to implement system edits to the extent possible under its current contract with CMS.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted for outpatient services.¹ Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process providers' outpatient claims, Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.² In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

NHIC, Corp.

In November 2008, CMS announced that it had awarded to NHIC, Corp. (NHIC), the MAC contract for Jurisdiction 14, which includes Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont.³ During our audit period (January 2006 through June 2009), approximately 145.8 million line items for outpatient services were processed in Jurisdiction 14.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges that NHIC made to providers for outpatient services were correct.

Scope

Of the approximately 145.8 million line items for outpatient services that NHIC processed during the period January 2006 through June 2009, 1,396 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$500 and (2) 3 or more units of service.⁴

We limited our review of NHIC's internal controls to those that were applicable to the selected 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.

Our fieldwork included contacting NHIC, located in Hingham, Massachusetts, and the 113 providers in Jurisdiction 14 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

³ Prior to the 2008 award, providers processed Medicare outpatient claims through separate fiscal intermediaries. After CMS awarded the MAC contract for Jurisdiction 14 to NHIC, NHIC immediately began implementation activities and assumed full responsibility for the Medicare Part A and Part B workload in June 2009. Therefore, NHIC is responsible for collecting any overpayments and resolving the issues related to this audit.

⁴ A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges."

- used CMS’s National Claims History file to identify outpatient line items in which (1) Medicare line payment amounts exceeded the line billed charge amounts by at least \$500 and (2) the line had 3 or more units of service;⁵
- identified 1,396 line items totaling approximately \$5.5 million that Medicare paid to 113 providers;
- contacted the 113 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with NHIC; and
- discussed the results of our review with NHIC on June 6, 2011.

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 findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 1,396 selected line items for which NHIC made Medicare payments to providers for outpatient services during our audit period, 559 were correct. Providers refunded overpayments on 81 line items totaling \$561,548 before our fieldwork. The remaining 756 line items were incorrect and included overpayments totaling \$3,168,213, which the providers had not refunded by the beginning of our audit.

Of the 756 incorrect line items:

- Providers reported incorrect units of service on 514 line items, resulting in overpayments totaling \$2,375,447.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 72 line items, resulting in overpayments totaling \$273,097.
- Providers used HCPCS codes that did not reflect the procedures performed on 116 line items, resulting in overpayments totaling \$271,041.

⁵ For this audit, we reviewed those line items that met the stated parameters. We applied these parameters to unadjusted line items. In some cases, subsequent payment adjustments reduced the difference between payments and charges to less than \$500.

- Providers billed for unallowable services on 52 line items, resulting in overpayments totaling \$218,872.
- Other errors on two line items resulted in overpayments totaling \$29,756.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NHIC made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

FEDERAL REQUIREMENTS

Section 1833(e) of the Social Security Act states: “No payment shall be made to any provider of services ... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid”

CMS’s *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 23, section 20.3, states: “providers must use HCPCS codes ... for most outpatient services.” Chapter 25, section 75.5, of the Manual states: “when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.” If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4”

Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported incorrect units of service on 514 line items, resulting in overpayments totaling \$2,375,447. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for incorrect service units on 53 line items. Rather than billing 1 service unit (the correct quantity for the HCPCS code associated with these line items), the provider billed 50 service units. According to the provider, these errors occurred because the provider’s pharmacy charge system and formulary were incorrect. As a result of these errors, NHIC paid the provider \$251,896 when it should have paid \$4,782, an overpayment of \$247,114.
- Another provider billed Medicare for incorrect service units on 46 line items. Rather than billing for 1 or 2 service units, the provider billed between 30 and 60 service units.

According to the provider, these errors occurred because the provider's billing system was programmed incorrectly. As a result of these errors, NHIC paid the provider \$99,743 when it should have paid \$4,867, an overpayment of \$94,876.

Combination of Incorrect Number of Units of Service and Incorrect Healthcare Common Procedure Coding System Codes

Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 72 line items. These errors resulted in overpayments totaling \$273,097. The following examples illustrate the combination of incorrect units of service claimed and incorrect HCPCS codes used:

- One provider billed Medicare for a drug HCPCS code with 33 units of service. However, the provider should have billed using a different HCPCS code with 500 units of service. This error occurred on four line items. As a result, NHIC paid the provider \$74,698 when it should have paid \$10,400, an overpayment of \$64,298.
- Another provider billed Medicare for incorrect service units on five line items. The provider incorrectly billed for four units of service for a surgical procedure when it should have billed for two units of service. For these same line items, this provider also used an incorrect surgical procedure code. As a result of these errors, NHIC paid the provider \$86,535 when it should have paid \$43,268, an overpayment of \$43,267.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 116 line items, resulting in overpayments totaling \$271,041. For example, because of human error, a provider billed Medicare for three line items with a HCPCS code for the drug Erbitux rather than using the correct HCPCS code for the drug Tysabri. As a result of these errors, NHIC paid the provider \$41,418 when it should have paid \$5,414, an overpayment of \$36,004.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for 52 line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling \$218,872. Specifically, 10 providers incorrectly billed Medicare outpatient services for dental procedures that are not covered by Medicare. For one such procedure, the provider billed for the repair of a tooth socket, which is not a covered procedure according to the *Medicare Benefit Policy Manual* (Pub. No. 100-02, chapter 15, section 150).

Other Errors

Two providers received incorrect payments from Medicare. One provider received a payment that was calculated incorrectly, and the other provider received a duplicate payment. NHIC paid the providers \$31,106 when it should have paid \$1,350, resulting in overpayments of \$29,756.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. NHIC made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.⁶

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires Medicare contractors to determine the legitimacy of the claims. However, this edit did not detect the errors that we found because the edit considers only the amount of the payment, suspends only those payments that exceed the threshold, and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that NHIC:

- recover the \$3,168,213 in identified overpayments,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

NHIC, CORP., COMMENTS

In written comments on our draft report, NHIC concurred with our recommendations. However, citing limitations within CMS's Part A processing system, NHIC stated that our second recommendation to implement system edits would "require additional clarification and discussion." NHIC's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We encourage NHIC to implement system edits to the extent possible under its current contract with CMS.

⁶ The Medicare contractor sends a *Medicare Summary Notice*—an explanation of benefits—to the beneficiary after the provider files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX

APPENDIX: NHIC, CORP., COMMENTS



NHIC, Corp.
MEDICARE ADMINISTRATIVE CONTRACTOR
JURISDICTION 14 A/B MAC

November 4, 2011

Department of Health & Human Services
Office of Inspector General
Office of Audit Services, Region 1
John F Kennedy Federal Building
Boston, MA 02203

Attention: Michael J. Armstrong
Regional Inspector General for Audit Services

Subject: Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by NHIC, Corp., in Jurisdiction 14 for the Period January 1, 2006, Through June 30, 2009 (A-01-10-00502)

Dear Mr. Armstrong:

NHIC appreciates the opportunity to work with the Office of Inspector General on this important issue to AB/MAC contractors. Please find on the following pages our response to the recommendations in the draft audit report cited above. If you have any questions about NHIC's response, please contact me as indicated below, and copy Jennifer Otten, Manager of Audit & Controls, in Chico, California (jennifer.otten@hp.com).

Sincerely,

/s/
Robert Harrington
Director
J14 A/B Medicare Administrative Contractor (MAC)
75 Sgt. William B Terry Drive
Boston, MA 02043
robert.harrington-jr@hp.com

cc: Anne Bockhoff-Dalton (NHIC Vice President)

www.medicarenhic.com

NHIC, Corp.

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A CMS CONTRACTOR

NHIC A/B MAC CMS Letterhead
TMP-ADM-0010, V1.0 07/06/2010

The controlled version of this document resides on the NHIC Quality Portal (SharePoint). Any other version or copy, either electronic or paper, is uncontrolled and must be destroyed when it has served its purpose.

Summary of OIG's recommendations and NHIC's response to each:

1. Recommendation

Recover the \$3,168,213 in identified overpayments.

NHIC Response.

*NHIC **concurs** with the recommendation and will proceed with the recovery as identified. The data provided indicates that there are over 700 claims to review. Our recovery effort should take between three and four weeks to complete, once properly identified and the older claims are brought back online. We will continue to monitor the recovery effort to ensure the dollars are recovered, depending upon current claim activity. Updated reports to OIG or CMS requestors are available upon request.*

2. Recommendation

Implement system edits to identify line item payments that exceeded billed charges by a prescribed amount.

NHIC Response

NHIC **concurs** with this recommendation. Our initial review indicates that the requested edits will require additional clarification and discussion. Due to system limitations within the CMS Part A processing system, it is unclear how a comparison may be made prior to moving through the Pricer. Financial calculations are completed once the claim is stored and ready to send to CWF.

We have no mechanism in FISS today that allows us to edit prepay for charged amount versus reimbursement amounts. However, we do have a new reason code 3719B that sets on the claim, when final, and which identifies claims that have a reimbursement higher than what was charged by the provider. The contractors could certainly do a post-pay review of these claims once CMS or the OIG provides the contractors with what action they want to occur after data analysis is performed on these claims. However, since the audit indicates that the vast majority of claims were paid on a fee schedule basis, the charged amount is not a key contributor to payment; rather, the charged code and units billed are the determining factors in correct or incorrect payment.

There is a possibility to suspend claims with certain APC or DRGs; however, a manual review of many claims would have to be completed. This type of edit would create significant additional workload.

If particular revenue codes or HCPC codes were identified in this review, NHIC could set up an edit to suspend those meeting predetermined criteria for units and/or amount billed. This effort would result in a smaller additional manual effort to set up, test, and move to production. Once in production,

there would need to be a prescribed review, either local or national, to maintain this edit for any needed updates.

In order to assess the feasibility of this potential remedy, NHIC would require more detailed audit findings or appropriate payment criteria in order to evaluate this approach, and it would be necessary to plan for this in the annual Medical Review strategy.

3. Recommendation

Use the results of this audit in its provider education activities.

NHIC Response

NHIC **concur**s with this recommendation. We have reviewed the report and have forwarded it to the consultants to provide education for providers on the issues noted. This may consist of writing educational articles and conducting direct education. We anticipate that education will be completed within the next three months.¹

¹ We have scheduled a session (via teleconference) in March of 2012 for OP services and excessive charges for OP services