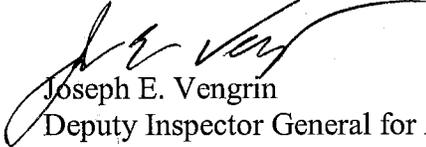




JAN -7 2009

**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 Medicare Part B Outpatient Claims Processed by National Government Services for the Period January 1, 2003, Through December 31, 2005 (A-02-07-01039)

Attached, for your information, is a copy of our final report on high-dollar payments for Medicare Part B outpatient claims processed by National Government Services for the period January 1, 2003, through December 31, 2005. These claims were submitted by providers in Connecticut, Delaware, and New York. 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 National Government Services' high-dollar Medicare payments to hospitals for outpatient services were appropriate.

Of the 166 high-dollar payments that we reviewed, 128 payments were appropriate. However, National Government Services overpaid hospitals \$14,590,399 for 38 claims. Hospitals refunded \$13,457,626 for 17 of the 38 overpayments prior to our fieldwork. At the start of our fieldwork, 21 overpayments totaling \$1,132,773 remained outstanding.

National Government Services made the overpayments because hospitals claimed incorrect units of service, billed incorrect charge amounts, used an incorrect Healthcare Common Procedure Coding System code, and did not have documentation supporting services billed. In addition, the Medicare claim processing systems did not have sufficient edits in place during calendar years 2003–2005 to detect and prevent payments for these types of erroneous claims.

We recommend that National Government Services:

- inform us of the status of the recovery of the \$1,132,773 in overpayments that our audit identified and
- use the results of this audit in its provider education activities.

In its comments on our draft report, National Government Services agreed with our recommendations.

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](mailto:George.Reeb@oig.hhs.gov) or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620 or through e-mail at [James.Edert@oig.hhs.gov](mailto:James.Edert@oig.hhs.gov). Please refer to report number A-02-07-01039.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

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Office Of Inspector General  
Office Of Audit Services

September 30, 2008

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

Report Number: A-02-07-01039

Ms. Sandra Miller  
President  
National Government Services  
8115 Knue Road  
Indianapolis, Indiana 46250

Dear Ms. Miller:

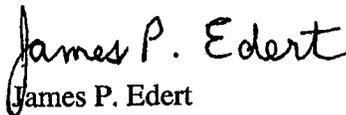
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Medicare Part B Outpatient Claims Processed by National Government Services for the Period January 1, 2003, Through December 31, 2005." We will 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, 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 Brenda Ryan, Audit Manager, at (212) 264-4677 or through e-mail at [Brenda.Ryan@oig.hhs.gov](mailto:Brenda.Ryan@oig.hhs.gov). Please refer to report number A-02-07-01039 in all correspondence.

Sincerely,

  
James P. Edert  
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 MEDICARE  
PART B OUTPATIENT CLAIMS  
PROCESSED BY NATIONAL  
GOVERNMENT SERVICES FOR  
THE PERIOD JANUARY 1, 2003,  
THROUGH DECEMBER 31, 2005**



Daniel R. Levinson  
Inspector General

September 2008  
A-02-07-01039

# ***Office of Inspector General***

<http://oig.hhs.gov>

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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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# *Notices*

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**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 (intermediaries) to process and pay Medicare institutional Part B (outpatient) claims submitted by providers. To process these claims, intermediaries use the Fiscal Intermediary Standard System, as well as CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

CMS guidance requires providers to bill accurately using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and to report units of service as the number of times that a service or procedure was performed. In addition, CMS guidance requires that providers maintain documentation to support services billed.

National Government Services (formerly Empire Medicare Services) is the intermediary for about 1,800 providers of outpatient services in Connecticut, Delaware, and New York. During our audit period (calendar years (CY) 2003–2005), National Government Services processed more than 20 million hospital outpatient claims, 172 of which resulted in payments of \$50,000 or more (high-dollar payments). We reviewed 166 of these payments, which excluded 6 payments adjusted by CMS or the U.S. Attorney's Office.

### **OBJECTIVE**

Our objective was to determine whether National Government Services' high-dollar Medicare payments to hospitals for outpatient services were appropriate.

### **SUMMARY OF FINDING**

Of the 166 high-dollar payments reviewed, which National Government Services made for outpatient services for CYs 2003–2005, 128 payments were appropriate. However, National Government Services overpaid hospitals \$14,590,399 for 38 claims. Hospitals refunded \$13,457,626 for 17 of the 38 overpayments prior to our fieldwork. At the start of our fieldwork, 21 overpayments totaling \$1,132,773 remained outstanding.

National Government Services made the overpayments because hospitals claimed incorrect units of service for 28 claims, billed incorrect charge amounts for 3 claims, used an incorrect HCPCS code for 1 claim, and did not have documentation supporting the services billed for 6 claims. 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 National Government Services:

- inform us of the status of the recovery of the \$1,132,773 in overpayments that our audit identified and
- use the results of this audit in its provider education activities.

## **NATIONAL GOVERNMENT SERVICES COMMENTS**

In its June 19, 2008, comments on our draft report, National Government Services agreed with our recommendations. National Government Services' comments appear 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 Fiscal Intermediaries**

CMS contracts with fiscal intermediaries (intermediaries) to, among other things, process and pay Medicare institutional Part B (outpatient) claims submitted by providers. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. CMS guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

#### **Claims for Outpatient Services**

Claims for outpatient services originate at the providers. Section 1861(u) of the Act (42 U.S.C. § 1395x) defines providers as hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and hospice programs. However, our audit was limited to claims submitted by hospitals; thus, the term "provider" as used throughout this report refers to hospitals.

CMS guidance requires providers to bill accurately using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and to report units of service as the number of times that a service or procedure was performed. To process providers' outpatient claims, intermediaries use the Fiscal Intermediary Standard System, as well as CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

During calendar years (CY) 2003–2005, providers nationwide submitted more than 134 million hospital outpatient claims to intermediaries. Of these, 1,243 claims resulted in payments of \$50,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

#### **National Government Services**

National Government Services (formerly Empire Medicare Services) is the intermediary for about 1,800 providers of outpatient services in Connecticut, Delaware, and New York. During CYs 2003–2005, National Government Services processed more than 20 million hospital outpatient claims, 172 of which resulted in high-dollar payments.

In January 2007, Empire Medicare Services combined its operations with those of four other companies and became National Government Services.<sup>1</sup> The name “National Government Services” used throughout this report refers to the intermediary formerly known as Empire Medicare Services.

### **Fiscal Intermediary Edits**

In January 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. According to the “Medicare Claims Processing Manual,” Publication No. 100-04, Transmittal No. 620, Change Request 3925, the edit suspends high-dollar outpatient claims and requires intermediaries to contact providers to determine the legitimacy of the claims.

In January 2007, CMS also required intermediaries 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 No. 100-08, Transmittal No. 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, HCPCS code, date of service, and billing provider against a specified number of units of service. Intermediaries must return claims to providers when the units of service billed exceed the specified number.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether National Government Services’ high-dollar Medicare payments to hospitals for outpatient services were appropriate.

### **Scope**

We reviewed 166 payments totaling \$23,481,186 that National Government Services processed during CYs 2003–2005. We did not review six payments totaling \$600,449 because CMS’s recovery audit contractor had adjusted five claims and the U.S. Attorney’s Office had adjusted one claim.

We limited our review of National Government Services’ internal controls to those applicable to the claims reviewed 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.

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<sup>1</sup>AdminaStar Federal; Anthem Health Plans of New Hampshire, Inc.; Associated Hospital Service; Empire Medicare Services; and United Government Services, LLC, combined operations and became National Government Services.

We performed our fieldwork from August 2007 to May 2008. Our fieldwork included contacting National Government Services, located in Indianapolis, Indiana, 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 172 Medicare outpatient claims with high-dollar payments processed by National Government Services during CYs 2003–2005;
- reviewed available Common Working File claim histories to determine whether the claims had been canceled and superseded by revised claims and 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 National Government Services.

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 166 high-dollar payments reviewed, which National Government Services made for outpatient services for CYs 2003–2005, 128 payments were appropriate. However, National Government Services overpaid hospitals \$14,590,399 for 38 claims. Hospitals refunded \$13,457,626 for 17 of the 38 overpayments prior to our fieldwork. At the start of our fieldwork, 21 overpayments totaling \$1,132,773 remained outstanding.

National Government Services made the overpayments because hospitals claimed incorrect units of service for 28 claims, billed incorrect charge amounts for 3 claims, used an incorrect HCPCS code for 1 claim, and did not have documentation supporting the services billed for 6 claims. 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**

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 HCPCS coding. CMS’s “Medicare Claims Processing Manual,” Publication No. 100-04, Chapter 4, section 20.4, defines a service unit as the number of times that the service or procedure being reported was performed. Furthermore, Chapter 1, section 80.3.2.2, of this manual states that, to be processed correctly and promptly, a bill must be completed accurately. In addition, according to the “Medicare Financial Management Manual,” Publication No. 100-06, Chapter 3, section 90.1(F), a provider is liable for an overpayment if the provider does not submit documentation to substantiate that it performed the services when questioned.

## **INAPPROPRIATE HIGH-DOLLAR PAYMENTS**

For 28 overpayments totaling \$14,099,778, providers billed for excessive units of service. The following examples illustrate the overstated units of service:

- A provider billed 50,002 units of service (doses of chemotherapy drugs) for 5 units delivered. The provider stated that it had entered the incorrect number of units for the dosage administered. As a result, National Government Services paid the provider \$3,491,432 when it should have paid \$1,749, an overpayment of \$3,489,683. The provider refunded the overpayment prior to our fieldwork.
- A provider billed 10,000 units of service (medical consultation for radiation treatment) for 1 unit delivered. The provider stated that it had entered the incorrect number of sessions furnished. As a result, National Government Services paid the provider \$621,855 when it should have paid \$3,487, an overpayment of \$618,368. The provider refunded the overpayment prior to our fieldwork.
- A provider billed 600 units of service (doses of a chemotherapy drug) for 60 units delivered. The provider stated that it had miscalculated the dosage administered because of an HCPCS code change. As a result, National Government Services paid the provider \$52,040 when it should have paid \$7,074, an overpayment of \$44,966. The provider refunded the overpayment during our fieldwork.

For three overpayments totaling \$329,443, providers billed incorrect charge amounts. For example, a provider billed \$250,000 for one unit of service (administration of an influenza virus vaccine) for which the charge amount should have been \$25. As a result, National Government Services paid the provider \$250,008 when it should have paid \$33, an overpayment of \$249,975. National Government Services recovered the overpayment prior to our fieldwork.

For one overpayment totaling \$57,255, the provider billed an incorrect HCPCS code. Specifically, the provider billed 15 units of high-dosage radiation therapy but provided 15 units of low-dosage radiation therapy. The provider stated that although the patient's dosage was decreased, the provider billed for the higher dosage. As a result, National Government Services paid the provider \$59,509 when it should have paid \$2,254, an overpayment of \$57,255. The provider refunded the overpayment during our fieldwork.

For the remaining six overpayments totaling \$103,923, providers did not have documentation in the patients' records supporting some of the services billed on individual claims. For example, a provider billed one unit of service (insertion of a pacing electrode) but did not have documentation in the patient's records to support the service. As a result, National Government Services paid the provider \$51,151 when it should have paid \$41,829, an overpayment of \$9,322. The provider refunded the overpayment during our fieldwork.

Providers attributed the incorrect claims to clerical errors made by their billing staffs. In addition, during CYs 2003–2005, the Fiscal Intermediary Standard System and the CMS Common Working File did not have sufficient edits in place to detect and prevent payments for these types of erroneous claims. Instead, CMS relied on providers to notify intermediaries of overpayments and on beneficiaries to review their "Medicare Summary Notice"<sup>2</sup> and disclose any overpayments.

## **RECOMMENDATIONS**

We recommend that National Government Services:

- inform us of the status of the recovery of the \$1,132,773 in overpayments that our audit identified and
- use the results of this audit in its provider education activities.

## **NATIONAL GOVERNMENT SERVICES COMMENTS**

In its June 19, 2008, comments on our draft report, National Government Services agreed with our recommendations. National Government Services' comments appear in their entirety as the Appendix.

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<sup>2</sup>The intermediary sends a "Medicare Summary Notice" to the beneficiary after the provider files a claim for Medicare service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

# **APPENDIX**



8115 Knue Road  
Indianapolis, Indiana 46250-1936  
www.NGSMedicare.com

A CMS Contracted Agent

## Medicare

June 19, 2008

Mr. James P. Edert  
Regional Inspector General for Audit Services  
Office of Inspector General, Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza  
New York, NY 10278

Re: Response to Draft Report Number A-02-07-01039

Dear Mr. Edert:

This letter is in response to the above referenced draft report entitled "Review of High-Dollar Payments for Medicare Part A Outpatient Claims Processed by National Government Services for the Period January 1, 2003 through December 31, 2005."

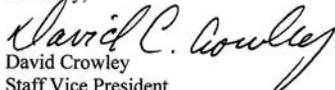
National Government Services (NGS) agrees with the audit recommendations noted in the draft report. NGS adjusted the claims billed/processed in error during the audit process and recovered all monies associated with these claims.

NGS has implemented several actions to prevent incorrect payments in the future. As noted in the audit report, an edit was implemented within the Fiscal Intermediary Standard System in January 2006 to suspend outpatient claims with a reimbursement of \$50,000 or more for further review and follow-up with providers to determine the legitimacy of the claims. Additionally, in January 2007 NGS implemented a "unit of service pre-payment edit" or 'Medically Unlikely Edits (MUEs)' in which claims are returned to providers when the units of service exceed the specified number.

Our Provider Outreach and Education Department will continue to provide further education activities to providers on the issues identified in the report so that future billings will be submitted in accordance with CMS regulations.

NGS appreciates the opportunity to respond to the draft report. Should you have further questions, please feel free to contact Cheryle Giamartino, Claims Manager, at 315-442-4704.

Sincerely,

  
David Crowley  
Staff Vice President  
Claims Management

cc: Sarah Litteral, Part A/RHHI Claims Director  
Cheryle Giamartino, Claims Manager

