



AUG 26 2009

Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

Report Number: A-03-07-00012

Mr. Patrick Kiley  
President  
Highmark Medicare Services  
1800 Center Street  
Camp Hill, Pennsylvania 17089

Dear Mr. Kiley:

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 Maryland and District of Columbia Outpatient Claims Processed by CareFirst of Maryland for the Period January 1, 2003, through September 30, 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 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 at (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through email at [Bernard.Siegel@oig.hhs.gov](mailto:Bernard.Siegel@oig.hhs.gov). Please refer to report number A-03-07-00012 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky  
Regional Inspector General  
for Audit Services

Enclosure

Copy:  
Mr. Jamie Bylotas  
Director, Quality & Performance Management

**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 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR  
PAYMENTS FOR MARYLAND AND  
DISTRICT OF COLUMBIA  
OUTPATIENT CLAIMS  
PROCESSED BY  
CAREFIRST OF MARYLAND  
FOR THE PERIOD JANUARY 1, 2003,  
THROUGH SEPTEMBER 30, 2005**



Daniel R. Levinson  
Inspector General

August 2009  
A-03-07-00012

# *Office of Inspector General*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments (providers). The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process payments for claims. The Common Working File can detect certain improper payments during prepayment validation.

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

CareFirst of Maryland (CareFirst) was the Medicare fiscal intermediary for Maryland and the District of Columbia from January 1, 2003, through September 30, 2005. CareFirst processed more than five million outpatient claims, 32 of which resulted in payments of \$50,000 or more. Highmark Medicare Services (Highmark) assumed CareFirst's business operations as Medicare fiscal intermediary for Maryland and the District of Columbia on October 1, 2005, and is responsible for resolving any issues identified in the report.

### **OBJECTIVE**

Our objective was to determine whether high-dollar Medicare payments that CareFirst made to providers for outpatient services were appropriate.

### **SUMMARY OF FINDINGS**

Of the 32 high-dollar payments that CareFirst made to 15 providers, 24 were inappropriate. The 24 payments included overpayments totaling \$1,208,485. Providers refunded \$381,110 of this amount prior to our audit and \$716,517 as a result of our audit. Providers had not refunded \$110,858 in overpayments for six claims at the time of our audit.

Providers received these overpayments by billing for excessive units of service or by billing for the wrong service or procedure. CareFirst made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place from January 1, 2003, through September 30, 2005, to detect and prevent the overpayments.

### **RECOMMENDATIONS**

We recommend that Highmark:

- recover the \$110,858 for the six identified overpayments and
- use the results of this audit in its provider education activities.

## **HIGHMARK MEDICARE SERVICES COMMENTS**

In written comments (Appendix) on our draft report, Highmark stated that it concurred with our recommendations. Highmark said that it will initiate action to recover the \$110,858 in identified overpayments and will include the results of this audit in its analysis of provider education activities.

**TABLE OF CONTENTS**

	<u>Page</u>
<b>INTRODUCTION</b> .....	1
<b>BACKGROUND</b> .....	1
Medicare Fiscal Intermediaries.....	1
Claims for Outpatient Services .....	1
CareFirst of Maryland and Highmark Medicare Services .....	1
<b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....	2
Objective .....	2
Scope.....	2
Methodology .....	2
<b>FINDINGS AND RECOMMENDATIONS</b> .....	3
<b>FEDERAL REQUIREMENTS</b> .....	3
<b>INAPPROPRIATE HIGH-DOLLAR PAYMENTS</b> .....	3
<b>CAUSES OF OVERPAYMENTS</b> .....	4
<b>FISCAL INTERMEDIARY PREPAYMENT EDIT</b> .....	4
<b>RECOMMENDATIONS</b> .....	4
<b>HIGHMARK MEDICARE SERVICES COMMENTS</b> .....	4
<b>APPENDIX</b>	
<b>HIGHMARK MEDICARE SERVICES COMMENTS</b>	



## INTRODUCTION

### BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

#### **Medicare Fiscal Intermediaries**

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments (providers). The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

To process providers' claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments during prepayment validation.

In calendar years (CY) 2003–2005, fiscal intermediaries processed and paid more than 409 million outpatient claims, 1,243 of which resulted in payments of \$50,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

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

Providers generate the claims for outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of service as the number of times that the service or procedure was performed.

#### **CareFirst of Maryland and Highmark Medicare Services**

CareFirst of Maryland (CareFirst) was the Medicare fiscal intermediary for Maryland and the District of Columbia from January 1, 2003, through September 30, 2005. CareFirst processed more than five million outpatient claims, 32 of which resulted in payments of \$50,000 or more. Highmark Medicare Services (Highmark)<sup>1</sup> assumed CareFirst's business operations as the Medicare fiscal intermediary for Maryland and the District of Columbia on October 1, 2005, and is responsible for resolving any issues identified in the report.

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<sup>1</sup>Highmark Medicare Services, a subsidiary of Highmark, Inc., is headquartered in Pittsburgh and has offices in Camp Hill and Williamsport, Pennsylvania.

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

### **Objective**

Our objective was to determine whether high-dollar Medicare payments that CareFirst made to providers for outpatient services were appropriate.

### **Scope**

We reviewed the 32 high-dollar payments for outpatient claims that CareFirst processed for Maryland and District of Columbia providers from January 1, 2003, through September 30, 2005. We limited our review of internal controls to those applicable to the 32 payments because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from March 2008 through June 2009. Our audit included contacting Highmark and the 15 providers that received the 32 high-dollar Medicare payments.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify outpatient claims with high-dollar payments;
- reviewed available Common Working File data for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims and whether payments remained outstanding at the time of our audit;
- contacted the providers that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect; and
- coordinated the calculation of overpayments and discussed the results of our review with Highmark.

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.

## **FINDINGS AND RECOMMENDATIONS**

Of the 32 high-dollar payments that CareFirst made to providers, 24 were inappropriate. The 24 payments included overpayments totaling \$1,208,485. Providers refunded \$381,110 of this amount prior to our audit and \$716,517 as a result of our audit. Providers had not refunded \$110,858 in overpayments for six claims at the time of our audit.

Providers received these overpayments by billing for excessive units of service or by billing for the wrong service or procedure. CareFirst made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place from January 1, 2003, through September 30, 2005, to detect and prevent the overpayments.

### **FEDERAL REQUIREMENTS**

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P. L. No. 99-509, requires providers to report claims for outpatient services using Healthcare Common Procedure Coding System codes. CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 4, section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of this manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" requires the fiscal intermediary to maintain adequate internal controls over Medicare automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments.

### **INAPPROPRIATE HIGH-DOLLAR PAYMENTS**

CareFirst made six overpayments for excessive units of service totaling \$110,858 which providers had not refunded at the time of our audit.

- For one overpayment, the provider billed for 200 units of rituximab, a cancer treatment drug, instead of 4 units. As a result, CareFirst overpaid the provider \$57,924.
- For one overpayment, the provider billed for 300 units of filgrastim, a chemotherapeutic drug, instead of 1 unit and 80 units of epoetin alpha, an anemia treatment drug, instead of 2 units. As a result, CareFirst overpaid the provider \$51,549.
- For one overpayment, the provider billed for 31 units of medical-surgical supplies, instead of 29 units. As a result CareFirst overpaid the provider \$491.
- For one overpayment, the provider billed for 50 units of pharmacy services, instead of 38 units. As a result CareFirst overpaid the provider \$399.
- For one overpayment, the provider billed for three units of medical-surgical supplies that it did not provide. As a result CareFirst overpaid the provider \$355.

- For one overpayment, the provider billed for 13 units of medical-surgical supplies, instead of 7 units. As a result, CareFirst overpaid the provider \$140.

Providers billed CareFirst for excessive units of service. As a result, CareFirst overpaid providers a total of \$110,858.

## **CAUSES OF OVERPAYMENTS**

The providers attributed the incorrect payments to clerical errors made by their billing staffs and to problems with incorrect data in their billing systems. In addition, during the audit period, CareFirst did not have sufficient prepayment or postpayment controls to identify overpayments at the payment level, and the Common Working File prepayment process lacked edits to detect and prevent excessive payments. In effect, CMS relied on providers to notify the intermediaries of excessive payments and on beneficiaries to review their “Medicare Summary Notice” and disclose any overpayments.<sup>2</sup>

## **FISCAL INTERMEDIARY PREPAYMENT EDIT**

On January 3, 2006, after our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends high-dollar outpatient payments greater than \$50,000 and requires intermediaries to determine the legitimacy of the payments.

## **RECOMMENDATIONS**

We recommend that Highmark:

- recover the \$110,858 for the six identified overpayments and
- use the results of this audit in its provider education activities.

## **HIGHMARK MEDICARE SERVICES COMMENTS**

In written comments on our draft report, Highmark stated that it concurred with our recommendations. Highmark said that it will initiate action to recover the \$110,858 in identified overpayments and will include the results of this audit in its analysis of provider education activities. Highmark’s comments are included in the Appendix.

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<sup>2</sup>The fiscal intermediary sends a “Medicare Summary Notice” to the beneficiary after the hospital files a claim for outpatient services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary

# **APPENDIX**



Stephen Virbitsky  
Regional Inspector General for Audit Services  
Office of Audit Services, Region III  
Public Ledger Building, Suite 316  
150 S. Independence Mall West  
Philadelphia, PA 19106-3499

August 19, 2009

OIG Report Number: A-03-07-0012

Dear Mr. Virbitsky:

The following are the Highmark Medicare Services' responses to your request for comments on the draft report entitled, "Review of High-Dollar Payments for Maryland and District of Columbia Outpatient Claims Processed by CareFirst of Maryland for the Period January 1, 2003 through September 30, 2005."

**Recommendation 1** – Recover \$110,858 for the six identified overpayments

**HMS Response:** HMS agrees with this recommendation and upon receipt of claim detail information, HMS will pursue recovery of the identified overpayments.

**Recommendation 2** – Use the results of this audit in provider education activities.

**HMS Response:** Highmark Medicare Services will include the results of this audit in our analysis of provider education activities. Highmark Medicare Services Informatics Team conducts proactive data analysis on an ongoing basis to determine unusual patterns and discover issues of risk for the Medicare program. This information is used as a resource in determining provider education activities.

Please do not hesitate to contact me at (717) 302-4410 if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "E. James Bylotas".

E. James Bylotas  
Director, Quality and Performance Management

CC: Bernard Siegel