



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

JUN 20 2008

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-08-00042

Ms. Lynda Northcutt, President
Cahaba Government Benefits Administrators, LLC
300 Corporate Parkway
Birmingham, Alabama 35242

Dear Ms. Northcutt:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Part B Claims Processed by Cahaba Government Benefits Administrators Carrier No. 00511 for the Period January 1, 2004, Through December 31, 2006." We will forward a copy of this report to the HHS action official 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 Eric Bowen, Audit Manager, at (404) 562-7789 or through e-mail at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-08-00042 in all correspondence.

Sincerely,

A handwritten signature in cursive script that reads "Peter J. Barbera".

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

Page 2 – Ms. Lynda Northcutt

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
PART B CLAIMS PROCESSED BY
CAHABA GOVERNMENT
BENEFITS ADMINISTRATORS
CARRIER No. 00511 FOR THE
PERIOD JANUARY 1, 2004,
THROUGH DECEMBER 31, 2006**



Daniel R. Levinson
Inspector General

June 2008
A-04-08-00042

Office of Inspector General

<http://oig.hhs.gov>

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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

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 carriers to process 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 System (MCS) and CMS's Common Working File to process Part B claims. These systems can detect certain improper payments during prepayment validation.

Cahaba Government Benefit Administrators (Cahaba GBA) under contract with CMS is responsible for Part B claims processing in Alabama, Georgia, and Mississippi under three separate contractor numbers. During calendar years (CY) 2004–2006, three Cahaba GBA carriers processed approximately 134 million Medicare Part B claims. Cahaba GBA contractor No. 00511 (the contractor) is the Medicare Part B carrier for about 26,300 providers in Georgia. During CYs 2004–2006, the contractor processed approximately 66 million Medicare Part B claims, 770 of which resulted in payments of \$10,000 or more (high-dollar payments). These high-dollar claims totaled \$14,475,131.

OBJECTIVE

Our objective was to determine whether the contractor's high-dollar payments to Georgia Part B providers were appropriate.

SUMMARY OF FINDINGS

The contractor made 747 of the 770 high-dollar payments to Georgia providers appropriately. However, we identified 23 overpayments totaling \$145,578. Providers refunded four of the overpayments totaling \$7,183 prior to issuance of our report. Generally, the contractor made the overpayments because the providers incorrectly billed excessive units of service. In addition, the Medicare claims processing systems did not have sufficient edits in place during CYs 2004–2006 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATION

We recommend that the contractor recover the \$138,395 in identified overpayments that has not been refunded.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS COMMENTS

In written comments to our draft report, Cahaba GBA agreed with the report. Cahaba GBA stated that the recommendations were reasonable and that it would wait for directions from CMS before acting on the recommendations and making adjustments. Cahaba GBA's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Part B Carriers	1
Cahaba Government Benefit Administrators	1
“Medically Unlikely” Edits	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology.....	2
FINDINGS AND RECOMMENDATION	3
MEDICARE REQUIREMENTS	3
INAPPROPRIATE HIGH-DOLLAR PAYMENTS	3
RECOMMENDATION	4
CAHABA GOVERNMENT BENEFIT ADMINISTRATORS COMMENTS	5
APPENDIX	
CAHABA GOVERNMENT BENEFIT ADMINISTRATORS 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), which administers the program, contracts with carriers to process Medicare Part B claims submitted by physicians and medical suppliers (providers).

Medicare Part B Carriers

Prior to 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 providers¹. 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 risk for overpayment.

Cahaba Government Benefit Administrators

Cahaba Government Benefit Administrators (Cahaba GBA) has been a Medicare contractor for CMS since the inception of the Medicare program in 1966. Cahaba GBA processes Part A, Part B, home health, and hospice claims. Cahaba GBA was also the CWF host for the Southeast Sector, the Pacific Sector, and the Great Lakes Sector during our audit period (CYs 2004–2006).

Cahaba GBA under contract with CMS is responsible for Part B claims processing in Alabama, Georgia, and Mississippi under three separate contractor numbers. During CYs 2004–2006 Cahaba GBA processed approximately 134 million Medicare Part B claims. Cahaba GBA carrier No. 00511 (the contractor) is the Medicare Part B carrier for about 26,300 providers in Georgia. During CYs 2004–2006, the contractor used the Medicare MCS to process approximately 66 million Medicare Part B claims, 770 of which resulted in payments of \$10,000 or more (high-dollar payments). These high-dollar payments totaled \$14,475,131.

We have examined Part B high-dollar payments for Cahaba GBA carrier No. 00512 (A-04-08-00037) and carrier No. 00510 (A-04-08-00041) under separate reviews.

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.

“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 code, dates 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 the contractor’s high-dollar payments to Georgia Part B providers were appropriate.

Scope

We reviewed the 770 high-dollar payments totaling \$14,475,131 that the contractor processed during CYs 2004–2006.

We limited our review of the contractor’s internal controls to those controls applicable to the 770 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 conducted our fieldwork from November 2007 through May 2008 by working with Cahaba GBA, located in Birmingham, Alabama, and the Georgia providers that received 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 Part B claims with high-dollar Medicare payments;
- reviewed available CWF claim histories for claims with high-dollar payments 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;

- contacted providers to determine whether high-dollar claims were billed and paid correctly and, if not, why the claims were billed or paid incorrectly; and
- coordinated our claims review with the contractor.

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 RECOMMENDATION

The contractor made 747 of the 770 high-dollar payments to Georgia providers appropriately. However, we identified 23 overpayments totaling \$145,578. Providers refunded four of the overpayments totaling \$7,183 prior to issuance of our report. Generally, the contractor made the overpayments because the providers incorrectly billed excessive units of service. In addition, the Medicare claims 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 general 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 . . . areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes.”

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

We identified 23 overpayments totaling \$145,578. For 20 overpayments providers incorrectly billed the contractor for excessive units of service, services not provided, and incorrect services. For three overpayments the provider reported that the contractor paid the claims incorrectly. The majority of the overpayments resulted from excessive units of service billed by the providers. In aggregate, providers billed 1,422 excessive units of service on 16 overpayments. Examples of these errors follow:

- One provider billed 300 units of the drug Avastin on a claim that should have been billed as 30 units of service. This error resulted in 270 excess units of service claimed and an overpayment of \$12,309.

- One provider billed 300 units of the drug Natalizumab Injection on a claim that should have been billed as 10 units of service. This error resulted in 290 excess units of service claimed and an overpayment of \$7,270.
- One provider billed 300 units of the drug Cetuximab Injection on a claim that should have been billed as 30 units of service. This error resulted in 270 excess units of service claimed and an overpayment of \$10,770.
- One provider billed 400 units of the drug Erbitux on a claim that should have been billed as 40 units of service. This error resulted in 360 excess units of service claimed and an overpayment of \$14,296.

In addition to the 16 overpayments for excessive units of service, providers received 4 overpayments for incorrect services or for services that were not provided as follows:

- One provider billed 123 units of service that were not provided. Among other things, the provider billed for 120 units of service for Bevacizumab Injection. These errors resulted in an overpayment of \$5,604.
- One provider billed 500 units of the drug Epirubicin but should have billed for Oxaliplatin. This error resulted in a \$6,462 overpayment. Additionally, this provider billed 25 units of the drug Campath but should have billed for the drug Camptosar. This error resulted in a \$7,843 overpayment.
- One provider billed 114 units of service for critical care (30 to 74 minutes) that should have been billed as critical care (75 to 104 minutes) or subsequent hospital care. These errors resulted in a \$2,187 overpayment.

The three reported contractor errors resulted in overpayments of \$6,187.

Generally, providers attributed the incorrect claims to clerical errors made by their billing staffs. In addition, during CYs 2004–2006, the Medicare MCS and the CMS Common Working File 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 the carriers of overpayments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider overpayments.²

RECOMMENDATION

We recommend that the contractor recover the \$138,395 in identified overpayments that has not been refunded.

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.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS COMMENTS

In written comments to our draft report, Cahaba GBA agreed with the report. Cahaba GBA stated that the recommendations were reasonable and that it would wait for directions from CMS before acting on the recommendations and making adjustments. Cahaba GBA's comments are included in their entirety as the Appendix.

APPENDIX



CAHABA
GOVERNMENT
BENEFIT
ADMINISTRATORS, LLC

Lynda Northcutt
President

Cahaba Government Benefit Administrators, LLC

APPENDIX

June 11, 2008

Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Attention: Eric Bowen, Audit Manager
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

RE: Report Number: A-04-08-0042 Review of High-Dollar Part B Claims Processed by
Cahaba Government Benefits Administrator Carrier No. 00511 for the Period January 1,
2004, Through December 31, 2006.

Dear Mr. Bowen,

We agree with the captioned report; its recommendations were reasonable. We await
direction from the Centers for Medicare and Medicaid Services before we act on the
recommendations and make adjustments.

If you should have any questions regarding this report, please contact Molly Echols,
Manager Risk and Compliance at (205) 220-1587 or via email at
Mechols@cahabagba.com.

Sincerely,

Lynda Northcutt
President
Cahaba Government Benefit Administrators®, LLC

LN/jm

cc: Brandon Ward, Vice President, Cahaba GBA Operations
David Brown, Director, Cahaba GBA Administration
Jim Hill, Divisional Manager, Cahaba GBA