



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

February 6, 2009

Report Number: A-06-08-00094

Mr. Jimmy Chaney
Director of Medical Claims
TriSpan Health Services
1064 Flynt Drive
Flowood, Mississippi 39232-9750

Dear Mr. Chaney:

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 Outpatient Claims Processed by TriSpan Health Services for the Period January 1 Through December 31, 2006." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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 (214) 767-8414, or contact Trish Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00094 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Gordon L. Sato".

 Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nan Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR
PAYMENTS FOR MEDICARE
OUTPATIENT CLAIMS
PROCESSED BY TRISPAN
HEALTH SERVICES FOR THE
PERIOD JANUARY 1 THROUGH
DECEMBER 31, 2006**



Daniel R. Levinson
Inspector General

February 2009
A-06-08-00094

Office of Inspector General

<http://oig.hhs.gov>

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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 to process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process claims. The Common Working File can detect certain improper payments during prepayment validation.

Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed.

During calendar year (CY) 2006, TriSpan Health Services (TriSpan), was the Medicare Part A fiscal intermediary serving more than 1,400 Medicare providers in Mississippi, Louisiana, and Missouri. For claims with dates of service in CY 2006, TriSpan processed more than 3.9 million outpatient claims, three of which resulted in payments of \$50,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDING

Of the three high-dollar payments that TriSpan made to one provider, two were appropriate. Regarding the remaining payment, TriSpan underpaid the provider \$13,856. TriSpan made the underpayment because the provider billed a Healthcare Common Procedure Coding System code using the incorrect revenue code for the service rendered.

RECOMMENDATIONS

We recommend that TriSpan:

- use the results of this audit in its provider education activities and
- consider identifying and reviewing additional high-dollar outpatient claims paid after CY 2006.

TRISPAN HEALTH SERVICES COMMENTS

In its comments on our draft report, TriSpan agreed with our finding and recommendations. The full text of TriSpan's comments is included as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Fiscal Intermediaries.....	1
Claims for Outpatient Services	1
TriSpan Health Services	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	2
FINDING AND RECOMMENDATIONS	3
FEDERAL REQUIREMENTS	3
INCORRECT HIGH-DOLLAR PAYMENT	3
CAUSE OF INCORRECT PAYMENT	3
RECOMMENDATIONS	4
TRISPAN HEALTH SERVICES COMMENTS	4
APPENDIX	
TRISPAN HEALTH SERVICES COMMENTS	

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. 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' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

In calendar year (CY) 2006, fiscal intermediaries processed and paid more than 140 million outpatient claims, 328 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 hospital services provided to Medicare beneficiaries and bill for those services using revenue codes. In addition to a revenue code, a claim may require a Healthcare Common Procedure Coding System (HCPCS) code for accurate claims processing. Revenue codes represent the categories under which HCPCS codes are billed. The payment for a HCPCS code that is billed under an incorrect revenue code will be calculated incorrectly.

TriSpan Health Services

During CY 2006, TriSpan Health Services (TriSpan), was the Medicare Part A fiscal intermediary serving more than 1,400 Medicare providers in Mississippi, Louisiana, and Missouri. For claims with dates of service in CY 2006, TriSpan processed more than 3.9 million outpatient claims, three of which were high-dollar payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the three high-dollar payments for outpatient claims that TriSpan processed during CY 2006. We limited our review of TriSpan's internal controls to those applicable to the three 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 a reasonable assurance of the authenticity and accuracy of the data in the three claims obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from August through November 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare outpatient claims with high-dollar payments;
- reviewed available Common Working File claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our audit;
- contacted the provider that received the high-dollar payments to determine whether the claims were billed correctly and, if not, why the claims were billed incorrectly; and
- coordinated our review, including any incorrect payment amounts, with TriSpan.

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 three high-dollar payments that TriSpan made to one provider, two were appropriate. For the remaining payment, TriSpan underpaid the provider \$13,856. TriSpan made the underpayment because the provider billed an HCPCS code using the incorrect revenue code for the service rendered.

FEDERAL 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 coding from the HCPCS. CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states that the number 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 the manual states: "To be processed correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INCORRECT HIGH-DOLLAR PAYMENT

TriSpan made one underpayment during CY 2006 because the provider billed an HCPCS code using the incorrect revenue code for the service rendered. The provider stated that it had billed HCPCS code C9224 using revenue code 250 instead of revenue code 636. As a result the payment was calculated differently and TriSpan paid the provider \$95,747 when it should have paid \$109,603, resulting in an underpayment totaling \$13,856.

CAUSE OF INCORRECT PAYMENT

During CY 2006, TriSpan employed a prepayment edit to suspend high-dollar outpatient claims that met or exceeded a reimbursement amount of \$50,000 and was required to contact providers that submitted high-dollar claims to determine the legitimacy of the claims. Although TriSpan employed the prepayment edit, neither its system nor the Common Working File had sufficient edits in place in CY 2006 to detect billing errors related to HCPCS and revenue codes. Instead, CMS relied on providers to notify intermediaries of incorrect payments and on beneficiaries to review their "Medicare Summary Notice" and disclose any inappropriate payments.¹

¹The fiscal intermediary sends an "Explanation of Medicare Benefits" 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.

RECOMMENDATIONS

We recommend that TriSpan:

- use the results of this audit in its provider education activities and
- consider identifying and reviewing additional high-dollar outpatient claims paid after CY 2006.

TRISPAN HEALTH SERVICES COMMENTS

In its comments on our draft report, TriSpan agreed with our finding and recommendations. In response to the first recommendation, TriSpan said that it plans to review the procedure codes identified in the report and publish frequently asked questions on its Web site to educate its providers on proper billings. TriSpan also said that it plans to include the information in any applicable presentations or teleconferences that it holds for providers during the fiscal year.

In response to the second recommendation, TriSpan said that it plans to obtain a listing of the universe of claims from the Fiscal Intermediary Standard System that meet the criteria described in the recommendation and review a random sample of those claims to determine whether there are a significant number of inappropriately billed claims. TriSpan stated that if the number is high, it will expand the scope of its review to possibly include the entire universe of claims.

The full text of TriSpan's comments is included as the Appendix.

APPENDIX



www.trispan.com

P. O. Box 23046 • Jackson, MS • 39225-3046

January 15, 2009

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Mr. Sato:

This letter provides written comments from TriSpan Health Services, Inc. related to the Office of Inspector General (OIG) draft report number A-06-08-00094 entitled "Review of High-Dollar Payments for Medicare Part A Outpatient Claims Processed by TriSpan Health Services for the Period January 1 Through December 31, 2006." For calendar year (CY) 2006, TriSpan processed more than 3.9 million outpatient claims, three of which resulted in payments of \$50,000 or more (high-dollar payments).

The audit objective was to determine whether the high-dollar Medicare payments that TriSpan made to hospitals for outpatient services were appropriate.

Among the three high-dollar payments that TriSpan made to providers, the following situations were found:

- Two claims were billed appropriately and no action was required
- TriSpan made one underpayment during CY 2006 because the provider billed an HCPCS code using the incorrect revenue code for the service rendered. The provider refiled the claim, and it was adjusted.

In the OIG draft report, there were two recommendations:

- 1) use the results of this audit in its provider education activities, and
- 2) consider identifying and reviewing additional high-dollar outpatient claims paid after CY 2006.



In response to the first recommendation, we will review the procedure codes identified in the report and publish Frequently Asked Questions on our Web site to educate our providers on proper billing as needed. We will also include this information in any applicable presentations or teleconferences held for our provider community during the fiscal year.

In response to the second recommendation, we plan to obtain a listing of the universe of claims from the FISS that meet the criteria described in the recommendation. We will review a random sample of the claims in the universe to determine if a significant number of inappropriately billed claims exist. If the number is high, we will have to expand the scope of our review to possibly include the entire universe of claims. Providers will be asked to submit adjustment claims to correct the incorrectly billed units of service.

The standard system currently has edits in place to suspend high-dollar outpatient claims for review, and there are some local edits in place for excessive units for services identified through data analysis and Comprehensive Error Rate Testing (CERT) findings. TriSpan will continue to add local edits as needed and educate providers on proper billing of units of service.

If you have any questions or comments regarding this letter, please feel free to call me at (601) 664-4229.

Sincerely,



Jimmy Chaney
Director, Medicare Systems, Claims, and Customer Service
TriSpan Health Services, Inc.