

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CGS ADMINISTRATORS, LLC,
OVERPAID PROVIDERS THAT
INCORRECTLY BILLED FOR
AFLIBERCEPT**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Patricia Wheeler
Regional Inspector General
for Audit Services

May 2015
A-06-14-00053

Office of Inspector General

<http://oig.hhs.gov>

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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.

INTRODUCTION

CGS Administrators, LLC, overpaid \$1,764,170 to providers that incorrectly billed for aflibercept.

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) pays Medicare claims through a Medicare administrative contractor (Medicare contractor) in each Medicare jurisdiction. Previous Office of Inspector General reviews have identified Medicare payments for outpatient drugs as vulnerable to incorrect coding.

OBJECTIVE

Our objective was to determine whether certain payments that the Medicare contractor for Jurisdiction 15, CGS Administrators, LLC (CGS), made to providers for aflibercept were correct.

BACKGROUND

Medicare Part B

Part B of Medicare provides supplementary medical insurance, including limited coverage for the cost of outpatient drugs and biologicals that are furnished incident to a physician's service and are not usually self-administered.¹ CMS administers Part B and contracts with Medicare contractors to, among other things, determine reimbursement amounts and pay claims, conduct reviews and audits, and safeguard against fraud and abuse. Medicare contractors must establish and maintain efficient and effective internal controls.²

Healthcare Common Procedure Coding System Codes

Medicare contractors pay providers using established rates for each hospital outpatient unit of service claimed, subject to any Part B deductible and coinsurance. Each submitted claim may contain multiple line items that detail most provided services. Providers must use standardized codes, called Healthcare Common Procedure Coding System (HCPCS) codes, for drugs administered and report units of service in multiples of the units shown in the HCPCS narrative description. For example, if the description for the HCPCS code specifies 50 milligrams (mg) and 200 mg are administered, units are shown as four on the claim.

CGS Administrators, LLC

During our audit period (July 1, 2012, through September 30, 2013), CGS was the Medicare contractor for Jurisdiction 15 (Ohio and Kentucky).

¹ CMS *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 50.

² CMS *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, section 10.1.2.

Aflibercept and Ziv-Aflibercept

Aflibercept is a drug used for the treatment of patients with age-related macular degeneration. Beginning July 2012, providers billed Medicare using HCPCS code Q2046 and then changed to J0178 effective January 2013. During our audit period, Medicare reimbursement was \$980.50 per 1 mg of aflibercept administered.³ The manufacturer recommended dose is 2 mg.

Ziv-aflibercept is a drug used in combination with other chemotherapy drugs to treat metastatic colorectal cancer. In August 2012, ziv-aflibercept became eligible for Medicare reimbursement but did not have an assigned HCPCS code. Beginning in January 2013, providers billed Medicare using HCPCS code C9296. During our audit period, Medicare reimbursement ranged from \$15.57 to \$11.10 per 1 mg administered.⁴ The manufacturer recommended dose is 4 mg per 2.2 pounds of body weight; thus, 400 mg would be the recommended dose for a 220-pound person.

HOW WE CONDUCTED THIS REVIEW

During our audit period, CGS paid \$6,033,886 in hospital outpatient services for 1,414 line items for aflibercept. We reviewed six line items, billed by two providers, with total payments of \$1,777,745 for aflibercept (HCPCS codes Q2046 or J0178) paid by CGS with diagnosis codes other than macular degeneration and with unit counts that exceeded the recommended dose. We did not review entire claims; rather, we reviewed specific line items within the claims.

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 objectives.

Appendix A contains the details of our audit scope and methodology.

FINDING

Payments that CGS made to providers for aflibercept for all six line items we reviewed were not correct. For all six line items, the two providers billed an incorrect HCPCS code. The providers attributed the incorrect billings to confusion caused by similar drug names. CGS made the overpayments because it relied on the providers to confirm that the line items were billed correctly. As a result, CGS paid the providers a total of \$1,777,745; it should have paid \$13,575, an overpayment of \$1,764,170.

³ Medicare Part B Drug Average Sales Price files maintained by CMS. Available online at <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html>. Accessed on March 16, 2015.

⁴ *Ibid.*

FEDERAL REQUIREMENTS

The Social Security Act (the Act) and CMS Pub. No. 100-04, *Medicare Claims Processing Manual* (the Manual), provide overall requirements related to the billing and payment of hospital outpatient services. They require that providers submit accurate and complete bills to Medicare for allowable and covered services and identify the number of units of service for each outpatient drug administered to a Medicare beneficiary using the correct HCPCS code.⁵

The Manual states that Medicare contractors must “edit for outpatient and inpatient Part B claims that meet or exceed a reimbursement amount of \$50,000” (chapter 1, section 140.1). The section further notes that Medicare contractors must “suspend those claims receiving the threshold edit for development and contact providers to resolve billing errors.” If a Medicare contractor determines that the reimbursement is excessive and corrections are required, the claim must be returned to the provider. If the billing is accurate and the reimbursement is not excessive, the Medicare contractor will override the edit and process the claim for payment.

INCORRECT HEALTHCARE COMMON PROCEDURE CODING SYSTEM CODE

The two providers billed the six line items using an incorrect HCPCS code. For all six line items, the providers administered ziv-aflibercept but billed for aflibercept. Providers attributed the incorrect billing to confusion caused by the two drugs’ similar names. CGS suspended the six line items when they were initially submitted but paid the line items after the providers confirmed that the line items were billed correctly. As a result, CGS paid the providers a total of \$1,777,745 when it should have paid \$13,575, an overpayment of \$1,764,170.

RECOMMENDATION

We recommend that CGS recover the \$1,764,170 in identified overpayments.

CGS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CGS agreed with the recommendation but disagreed with the report title. CGS officials requested that CGS’s name be removed from the title of this report. They stated that the overpayments were initiated by oversight in the providers’ billing practices for aflibercept rather than an error in processing the claims. CGS’s comments are included in their entirety as Appendix B.

We modified the report title to reflect that the providers incorrectly billed for aflibercept.

⁵ The Act, section 1833(e), and the Manual, chapter 17, section 90.2.A.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For the period July 1, 2012, through September 30, 2013, we limited our review to determining whether the HCPCS codes submitted on selected outpatient claims that resulted in high-dollar Medicare payments for aflibercept were supported by providers' medical record documentation. We did not review entire claims; rather, we reviewed specific line items within the claims.

We limited our review of the provider'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.

We conducted our audit work from August 2014 through January 2015 by contacting the Medicare contractor in Tennessee, and providers in Kentucky and Ohio.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and guidance;
- analyzed CMS's National Claims History file to identify high-dollar outpatient claims for aflibercept potentially at risk for noncompliance with selected Medicare billing requirements;
- reviewed available data for the selected claims to determine whether the claims had been cancelled or adjusted;
- identified six line items totaling \$1,777,745 for aflibercept (HCPCS codes Q2046 or J0178) paid by the Medicare contractor and having diagnosis codes other than the one used for macular degeneration and unit counts that exceeded the recommended dose;
- contacted the providers to determine whether the HCPCS codes for the selected line items were correct and, if not, why the HCPCS codes were incorrect;
- requested that the providers review the patient medical records, specifically the physician orders and drug administration records, to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with the Medicare contractor; and
- discussed the results of our review with Medicare contractor officials.

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 objectives.

APPENDIX B: CGS COMMENTS

John Kimball
Vice President, Operations
CGS Administrators, LLC



April 24, 2014

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RE: CGS Response to Draft OIG Report entitled *CGS Administrators, LLC, Overpaid Providers for Aflibercept (A-06-14-00053)*

Dear Ms. Patricia Wheeler,

CGS Administrators, LLC, the Part A/B and Home Health and Hospice Medicare Administrative Contractor for Jurisdiction 15, appreciates the opportunity to comment on the Office of Inspector General's draft report entitled *CGS Administrators, LLC, Overpaid Providers for Aflibercept (A-06-14-00053)*. In addition to requesting comments on the report, you ask that CGS state concurrence or nonconcurrence with the recommendation in the report.

The OIG made the following recommendation in its report:

1. That CGS recover the \$1,764,170 in identified overpayments.

CGS concurs with the recommendation outlined in the OIG draft report entitled *CGS Administrators, LLC, Overpaid Providers for Aflibercept (A-06-14-00053)* to recover the \$1,764,170 in identified overpayments. CGS maintains that we had controls in place to identify these claims and verify their accuracy with the providers and that the overpayments were caused by provider oversight. The providers have made the necessary adjustments on their end and the six overpayments totaling \$1,764,170 have been recouped by CGS in their entirety.

While CGS agrees with the recommendation outlined in this report, CGS disagrees with the title of the report. CGS requests that their name be removed from the title of this report. The overpayments were initiated by oversight in providers' billing practices for Aflibercept. CGS did not error in the processing of these claims.

Thank you for providing CGS the opportunity to comment prior to the issuance of the final report. Should you have any additional questions, please feel free to contact Jacqueline Yarbrough at 615.782.4671 or Jacqueline.Yarbrough@cgsadmin.com.

Sincerely,
John Kimball

John Kimball
Vice President, Operations

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