



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

October 2, 2008

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Report Number: A-07-08-04131

Mr. Guy Ringle
Senior Vice President
Medicare Division
Wisconsin Physicians Service
1717 West Broadway
Madison, Wisconsin 53713

Dear Mr. Ringle:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Wisconsin Physicians Service Insurance Corporation High-Dollar Payments for Medicare Part B Claims Processed by Wheatlands Administrative Services, Inc., 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.

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If you have any questions or comments about this report, please do not hesitate to call me, or contact Raylene Mason, Audit Manager, at (816) 426-3203 or through e-mail at Raylene.Mason@oig.hhs.gov. Please refer to report number A-07-08-04131 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick J. Cogley".

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosure

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 WISCONSIN
PHYSICIANS SERVICE INSURANCE
CORPORATION HIGH-DOLLAR
PAYMENTS FOR MEDICARE PART B
CLAIMS PROCESSED BY
WHEATLANDS ADMINISTRATIVE
SERVICES, INC., FOR THE PERIOD
JANUARY 1, 2003, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

October 2008
A-07-08-04131

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.

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

During our audit period (calendar years (CY) 2003 through 2005), Wheatlands Administrative Services, Inc. (Wheatlands), was the Medicare Part B carrier serving Medicare providers in Kansas, Nebraska, and western Missouri. During this period, Wheatlands processed approximately 50.5 million Part B claims, 348 of which had payments of \$10,000 or more. We considered these high-dollar claims to be at risk for overpayment.

On March 1, 2008, CMS awarded the carrier contract for Kansas, Nebraska, and western Missouri to Wisconsin Physicians Service Insurance Corporation (WPS). Although Wheatlands processed the Medicare Part B claims for the audit period we reviewed, WPS has since assumed responsibility as the Medicare Part B carrier serving Medicare providers in Kansas, Nebraska, and western Missouri. Therefore, we are issuing our report to WPS because (a) Wheatlands no longer has access to the Medicare Part B processing system and (b) as the carrier, WPS has assumed the responsibility to ensure that the claims have been corrected.

OBJECTIVE

Our objective was to determine whether high-dollar Medicare claims that Wheatlands processed and paid to Kansas, Nebraska, and western Missouri Part B providers were appropriate.

SUMMARY OF FINDING

Of the 348 high-dollar claims that Wheatlands paid to providers, 335 were appropriate. However, Wheatlands overpaid providers \$105,940 for the remaining 13 payments. Providers refunded 6 of the overpayments, totaling \$53,857, prior to our fieldwork. However, 7 overpayments, totaling \$52,083, remained outstanding as of the time of our fieldwork.

Wheatlands made the overpayments because the providers incorrectly claimed excessive units of service or because Wheatlands applied incorrect payment rates for procedure codes. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003 through 2005 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that WPS:

- recover the \$52,083 in overpayments,
- use the results of this audit in its provider education activities, and
- identify and recover any additional overpayments made for high-dollar Part B claims paid after CY 2005.

AUDITEE COMMENTS

In written comments on our draft report, WPS agreed with our findings and recommendations. WPS's comments are included 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 Part B Carriers

Before 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 physicians and medical suppliers (providers).¹ Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary use of services. To process providers' claims, carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File. 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) 2003 through 2005, providers nationwide submitted over 2.3 billion Medicare Part B claims to carriers. Of these, 29,022 claims resulted in payments of \$10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

Wisconsin Physicians Service Insurance Corporation

During our audit period, Wheatlands Administrative Services, Inc. (Wheatlands), was the Medicare Part B carrier serving Medicare providers in Kansas, Nebraska, and western Missouri. During this period, Wheatlands processed approximately 50.5 million Part B claims that had payments of approximately \$4 billion. Of these claims, Wheatlands processed 348 Part B claims that had high-dollar payments. On March 1, 2008, CMS awarded the carrier contract for Kansas, Nebraska, and western Missouri to Wisconsin Physicians Service Insurance Corporation (WPS).

“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, date 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.

¹The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P. 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare claims that Wheatlands processed and paid to Kansas, Nebraska, and western Missouri Part B providers were appropriate.

Scope

We reviewed the 348 high-dollar claims, totaling \$8,503,220, that Wheatlands processed during CYs 2003 through 2005.

We limited our review of Wheatlands' internal controls to those applicable to the 348 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 fieldwork from May 2007 through July 2008. Our fieldwork included contacting Wheatlands, located in Topeka, Kansas, and the providers that received the payments for the high-dollar claims.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify Medicare Part B 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 payments remained outstanding at the time of our fieldwork;
- coordinated our claim review with Wheatlands;
- contacted providers to determine whether the high-dollar claims were billed correctly;
- obtained documentation from the providers confirming all correct claims identified; and
- provided supporting documentation for all the incorrect claims identified to WPS on August 25, 2008.

Although Wheatlands processed the Medicare Part B claims for the audit period we reviewed, WPS has since assumed responsibility as the Medicare Part B carrier serving Medicare providers

in Kansas, Nebraska, and western Missouri. Therefore, we are issuing our report to WPS because (a) Wheatlands no longer has access to the Medicare Part B processing system and (b) as the carrier, WPS has assumed the responsibility to ensure that the claims have been corrected.

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 RECOMMENDATIONS

Of the 348 high-dollar claims that Wheatlands paid to providers, 335 were appropriate. However, Wheatlands overpaid providers \$105,940 for the remaining 13 payments. Providers refunded 6 of the overpayments, totaling \$53,857, prior to our fieldwork. However, 7 overpayments, totaling \$52,083, remained outstanding.

Wheatlands made the overpayments because the providers incorrectly claimed excessive units of service or because Wheatlands applied incorrect payment rates for procedure codes. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003 through 2005 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 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 . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes.”

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

For 5 overpayments, totaling \$45,135, providers incorrectly billed Wheatlands for excessive units of service:

- One provider billed 3 units of service when it should have billed 1 unit, resulting in an overpayment of \$1,482.
- One provider billed 50 units of service when it should have billed 1 unit, resulting in an overpayment of \$12,526.
- One provider billed 6 units of service when it should have billed 1 unit, resulting in an overpayment of \$9,975.

- One provider billed 45 units of service when it should have billed 7 units, resulting in an overpayment of \$12,946.
- One provider billed 4 units of service when it should have billed 1 unit, resulting in an overpayment of \$8,206.

For the remaining 2 overpayments, Wheatlands applied incorrect payment rates for hemophilia drugs, procedure codes J7190 and J7192. As a result, Wheatlands paid the provider \$36,208 when it should have paid \$29,260, an overpayment of \$6,948. We could not determine the source of the payment rates used. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

Providers attributed the submission of claims with incorrect units of service to clerical errors made by their billing staffs. In addition, during CYs 2003 through 2005, the Medicare Multi-Carrier Claims System 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 carriers of overpayments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider overpayments.²

RECOMMENDATIONS

We recommend that WPS:

- recover the \$52,083 in overpayments,
- use the results of this audit in its provider education activities, and
- identify and recover any additional overpayments made for high-dollar Part B claims paid after CY 2005.

AUDITEE COMMENTS

In written comments on our draft report, WPS agreed with our findings and recommendations. WPS’s comments are included in their entirety as the Appendix.

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.

APPENDIX



Medicare

September 26, 2008

Ms. Raylene Mason
Regional Office Inspector General, Office of Audit Svcs.
601 East 12th Street
Kansas City, Missouri 64106

Re : CIN A-07-08-04131

Dear Ms. Mason,

This correspondence is in response to the Office of the Inspector General's review and report of excessive Medicare payments for Wheatlands Administrative Services, Inc., for the period of January 1, 2003 through December 31, 2005.

As the Medicare Administrative Contractor (MAC) for Jurisdiction 5, Wisconsin Physicians Service (WPS) assumed responsibility for Kansas Medicare claims on March 1, 2008.

WPS has reviewed the claim samples identified for the seven Medicare Beneficiaries. We concur with the OIG overpayment rationales on all seven cases. Wheatland's Administrative Services overpaid on these said claims due to provider billing errors on excessive units of service.

Please find below listed WPS response to each individual recommendation:

Recommendation #1 Recover the \$52, 083 in overpayments

WPS agrees with this recommendation. We will identify and pursue any outstanding overpayments. To-date, partial refunds have been received on three cases in the amount of \$31, 922.37.

Recommendation #2 Use the Results of Audit Provider Educational Activities

WPS agrees with this recommendation and will explore protocols for collecting and evaluating data and provide educational guidance to Medicare Providers underscoring the importance of the accurate billing practices.

Recommendation #3 Identify and Recover Any Additional Overpayments Medicare Part B High-Dollar Claims paid after CY 2005

WPS agrees with this recommendation. We will make every effort to recover any additional overpayments identified for High Dollar Medicare Part B claims on the basis of incorrect provider billings.



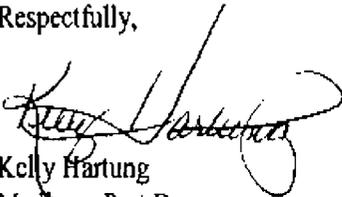
Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare Contractor
P.O. Box 1787 • Madison, WI 53701 • Phone 608-221-4711

Ms. Raylene Mason
CIN A-07-08-04131

September 26, 2008
Page 2

Thank you for the opportunity to respond to this report. If you have any questions, please contact me.

Respectfully,

A handwritten signature in black ink, appearing to read "Kelly Hartung", written over a thin horizontal line.

Kelly Hartung
Medicare Part B
Contract Coordination Manager
Wisconsin Physicians Service (WPS)
Email: Kelly.Hartung@wpsic.com
Phone: (618) 998-5196 Fax: (618) 998-5209

Cc : Rodney G. Brown, OIG