



May 2, 2011

Report Number: A-07-10-01091

Ms. Jared A. Adair  
Senior Vice President, Medicare Division  
Wisconsin Physicians Service Insurance Corporation  
1717 West Broadway  
P.O. Box 8190  
Madison, WI 53708

Dear Ms. Adair:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Fee-for-Service Payments Made by Wisconsin Physicians Service Insurance Corporation for Medicare Advantage Enrollees During Calendar Years 2007 and 2008*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Scott Englund, Audit Manager, at (573) 893-8338, extension 57, or through email at [Scott.Englund@oig.hhs.gov](mailto:Scott.Englund@oig.hhs.gov). Please refer to report number A-07-10-01091 in all correspondence.

Sincerely,

/Patrick J. Cogley/  
Regional Inspector General  
for Audit Services

Enclosure

Page 2 – Ms. Jared A. Adair

**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 12th Street, Room 235  
Kansas City, MO 64106

Department of Health & Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE  
FEE-FOR-SERVICE PAYMENTS  
MADE BY WISCONSIN PHYSICIANS  
SERVICE INSURANCE CORPORATION FOR  
MEDICARE ADVANTAGE ENROLLEES  
DURING CALENDAR YEARS  
2007 AND 2008**



Daniel R. Levinson  
Inspector General

May 2011  
A-07-10-01091

# *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 Act), the Medicare program provides health insurance for people aged 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 Medicare contractors to process and pay Medicare claims submitted by hospitals. The Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 revised Medicare Part C. Among its changes, this law renamed the Medicare+Choice program the Medicare Advantage program. Medicare Advantage organizations (MA organizations) receive capitation payments from CMS to arrange and pay for all medically necessary services that are allowable in the traditional Medicare fee-for-service (FFS) program. Under Medicare Part C, Medicare beneficiaries may enroll in Medicare Advantage plans (MA plans) that are offered by MA organizations.

Pursuant to Section 1886(d) of the Act, 42 CFR § 412.1(a) established the prospective payment system (PPS) for Medicare inpatient hospital services. Under the PPS, Medicare contractors will not make Medicare FFS payments for certain inpatient services, such as bed and board, nursing services, and drugs, furnished to Medicare Advantage enrollees.

For inpatient claims, the status of the beneficiary's enrollment in an MA plan on the hospital admission date determines whether the MA organization or the Medicare contractor has payment responsibility. MA organizations have payment responsibility for claims with services that began on or after the Medicare Advantage enrollment date. Medicare contractors have payment responsibility for claims with services that began before the Medicare Advantage enrollment date.

Wisconsin Physicians Service Insurance Corporation (WPS) was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 5 contract on September 5, 2007. With this award, WPS acquired Mutual of Omaha's Medicare Part A business segment in November 2007.

## **OBJECTIVE**

Our objective was to determine whether Medicare FFS payments made by WPS to hospitals for inpatient services furnished to Medicare Advantage enrollees complied with Federal regulations.

## **SUMMARY OF FINDINGS**

Medicare FFS payments made by WPS to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. WPS made \$164,193 in unallowable payments to hospitals for inpatient claims for beneficiaries who were enrolled in MA plans.

WPS was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases WPS did not receive an Informational Unsolicited Response (IUR) from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

WPS had not taken action on these 22 improper payments prior to our fieldwork.

## **RECOMMENDATIONS**

We recommend that WPS:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government \$164,193 of improper payments from providers and
- generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history.

## **AUDITEE COMMENTS**

In written comments on our draft report, WPS stated that it had adjusted 22 of the identified claims and, on that basis, had identified an overpayment of \$164,193. WPS also noted that 1 of the 22 claims was eligible for a payment of \$1,650. Regarding the fact that our draft report had identified 28 improper payments, WPS stated that 6 of the payments were made correctly: 5 related to qualified clinical trials and the other payment involved a claim whose dates of service were prior to the Medicare Advantage enrollment effective date.

WPS's comments are included in their entirety as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing WPS's written comments, we verified that 6 of the 28 improper payments identified in our draft report were in fact made correctly, and we revised our findings and recommendations accordingly. We also verified that the eligible payment of \$1,650 was in fact made correctly and that this amount is not included in the \$164,193 of improper payments identified in our finding.

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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 aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

### Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted by hospital inpatient departments.<sup>1</sup> The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process hospitals' inpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

### Medicare Advantage Program

The Balanced Budget Act of 1997, P.L. No. 105-33, established Medicare Part C to offer beneficiaries managed care options through the Medicare+Choice program. Managed care organizations include health maintenance organizations, preferred provider organizations, provider-sponsored organizations, and private fee-for-service organizations. Section 201 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 revised Medicare Part C. Among its changes, this law renamed the Medicare+Choice program the Medicare Advantage program. Medicare Advantage organizations (MA organizations) receive capitation payments from CMS to arrange and pay for all medically necessary services that are allowable in the traditional Medicare fee-for-service (FFS) program. Under Medicare Part C, Medicare beneficiaries may enroll in Medicare Advantage plans (MA plans) that are offered by MA organizations.

### Claims for Inpatient Services

Pursuant to Section 1886(d) of the Act, 42 CFR § 412(a)(1) established the prospective payment system (PPS) for Medicare inpatient hospital services. Under the PPS, Medicare contractors will not make Medicare FFS payments for certain inpatient services, such as bed and board, nursing services, and drugs, furnished to Medicare Advantage enrollees.

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<sup>1</sup> Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

## **Claims for Inpatient Services Provided to Medicare Advantage Enrollees**

CMS is responsible for ensuring that Medicare payments are made correctly. Weekly, MA organizations transmit enrollment data to CMS, including information on when each Medicare beneficiary enrolled and/or disenrolled in his or her MA plan. CMS maintains the enrollment data on the Medicare Advantage Prescription Drug system (MARx), a system that is intended to contain data on every Medicare beneficiary enrolled in an MA plan. CMS uses the enrollment data on the MARx to update the enrollment data in the CWF, which is intended to contain eligibility information for every Medicare beneficiary.

When hospitals submit claims for inpatient service, eligibility is verified through the CWF. If the CWF indicates that the beneficiary is a member of an MA plan, the Medicare contractor should deny the claim; however, there are some exceptions. For example, a provider may be reimbursed on an FFS basis for a Medicare Advantage enrollee who elects hospice coverage or who receives a service classified as a national coverage determination.<sup>2</sup> A provider may also be reimbursed for direct graduate medical education costs, indirect medical education costs, and services to Medicare beneficiaries in clinical trials.

For inpatient claims, the status of the beneficiary's enrollment in an MA plan on the hospital admission date determines whether the MA organization or the Medicare contractor has payment responsibility. MA organizations have payment responsibility for claims with services that begin on or after the Medicare Advantage enrollment date. Medicare contractors have payment responsibility for claims with services that begin before the Medicare Advantage enrollment date.

### **Retroactive Enrollment**

A retroactive enrollment occurs when enrollment data are entered in the MARx after the beneficiary's actual enrollment date. For example, if a beneficiary enrolled in an MA plan on January 1, 2007, but the enrollment data were not entered in the MARx until January 30, 2007, the MARx would retroactively list the actual enrollment date as January 1, 2007. The actual enrollment date should then be updated in the CWF.

The CWF generates an Informational Unsolicited Response (IUR) which provides the identifying information regarding the claim submitted for a beneficiary retroactively enrolled in an MA plan. The CWF electronically transmits the IUR to the Medicare contractor that originally processed the claim.

Upon receipt of the IUR, the Medicare contractor must initiate overpayment recovery procedures to retract the original Part A and Part B payments. The Medicare contractor must also generate an adjustment to update or cancel the claim; this adjustment, in turn, updates both the CWF and the contractor history.

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<sup>2</sup>A national coverage determination indicates coverage for a new service that was not included in the calculation of the managed care capitation payment.

## **Wisconsin Physicians Service Insurance Corporation**

Wisconsin Physicians Service Insurance Corporation (WPS) was awarded the CMS Parts A and B Medicare administrative contractors (MAC) Jurisdiction 5 contract on September 5, 2007. With this award, WPS acquired Mutual of Omaha's Medicare Part A business segment in November 2007.

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

#### **Objective**

Our objective was to determine whether Medicare FFS payments made by WPS to hospitals for inpatient services furnished to Medicare Advantage enrollees complied with Federal regulations.

#### **Scope**

Our audit included FFS payments made by WPS and Mutual of Omaha for certain inpatient services furnished to Medicare Advantage enrollees who were enrolled in MA plans nationwide for at least 1 month during calendar years (CY) 2007 and 2008. We reviewed internal controls to the extent necessary to accomplish the audit objective.

#### **Methodology**

To accomplish our objective, we:

- reviewed Federal regulations related to payment liability for Medicare beneficiaries enrolled in MA plans, as well as program manuals and memorandums, issued by CMS to Medicare contractors, that provided instructions on which claims to pay;
- used the Enrollment Database to identify beneficiaries enrolled in an MA plan during CY 2007;
- obtained inpatient claims data for CYs 2007 and 2008 from the National Claims History and Standard Analytical Files for those beneficiaries enrolled in MA plans;
- identified Medicare FFS inpatient claims for services that began on or after the date that the beneficiary enrolled in the MA plan and before the beneficiary disenrolled from the MA plan;
- eliminated paid claims for enrollees who elected hospice coverage before being admitted to the hospital;
- eliminated paid claims for graduate medical education costs, indirect medical education costs, and costs associated with clinical trials;

- verified, using information in the CWF, both the eligibility of the Medicare beneficiary and the accuracy of the payment amount, and ensured that the payment had not been canceled;
- provided WPS with detail data regarding 150 claims totaling \$1,596,893 that were potentially paid in error, and, after discussing the possible causes of claims that were potentially paid in error with WPS officials:
  - eliminated 73 improper payments totaling \$850,871 that had been cancelled and recouped prior to the start of our fieldwork and
  - eliminated 49 payments totaling \$500,477 that were properly paid; and
- discussed the results of our review with WPS officials and provided them with the details of the 28 claims for which we had identified improper payments.

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**

Medicare FFS payments made by WPS to hospitals for inpatient services furnished to Medicare Advantage enrollees did not always comply with Federal regulations. WPS made \$164,193 in unallowable payments to hospitals for inpatient claims for beneficiaries who were enrolled in MA plans.

WPS was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases WPS did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

WPS had not taken action on these 22 improper payments prior to our fieldwork.

## **FEDERAL REQUIREMENTS**

Pursuant to 42 CFR § 412.20(e)(3), inpatient hospital services will not be paid on an FFS basis if “[t]he services are paid for by an [MA organization] ... that elects not to have CMS make payments directly to a hospital for inpatient hospital services furnished to the [MA organization’s] ... Medicare enrollees....”

CMS's manuals instruct hospitals and Medicare contractors about the payment liability for inpatient services for Medicare Advantage enrollees. Section 408 of CMS's *Hospital Manual* states: "If you are a PPS hospital and the patient changes his [Medicare Advantage] status during an inpatient stay, his status at admission determines liability. If he was enrolled in the [MA organization] before admission, the [MA organization] is responsible regardless of whether he disenrolled before discharge." Section 3654.1 of CMS's *Medicare Intermediary Manual* instructs Medicare contractors to "... not make a duplicate payment for the same services [for which] the [MA organization] has paid."

## **IMPROPER MEDICARE FEE-FOR-SERVICE PAYMENTS**

For CYs 2007 and 2008, 22 FFS payments made by WPS totaling \$164,193 for inpatient claims for beneficiaries who were enrolled in MA plans were improper. For example, one payment for \$12,666 was made for an inpatient stay beginning on March 2, 2007, for a beneficiary who was enrolled in an MA plan from March 1, 2007, to March 31, 2007.

WPS was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments. Additionally, in each of these cases WPS did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan. As a result, WPS was unaware that the improper payments had been made. Therefore it did not initiate overpayment recovery procedures to recoup the original payments, and it did not generate an adjustment to update or cancel the claim in order to update both the CWF and the contractor history.

We determined that at the time of the payments, controls were in place to verify the beneficiaries' enrollment status, and to promptly generate IURs in cases of retroactive enrollments. These controls were adequate to stop improper FFS payments for services furnished to the vast majority of Medicare Advantage enrollees.

WPS had not taken action on these 22 improper payments prior to our fieldwork.

## **RECOMMENDATIONS**

We recommend that WPS:

- initiate overpayment recovery procedures to recoup and reimburse to the Federal Government \$164,193 of improper payments from providers and
- generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history.

## **AUDITEE COMMENTS**

In written comments on our draft report, WPS disagreed with the finding, as expressed in our draft report, that "WPS did not always comply with Federal regulations in making Medicare FFS

payments to hospitals for inpatient services furnished to Medicare Advantage enrollees.” WPS said that it had complied with Federal regulations in making these payments. WPS also stated that it had adjusted 22 of the identified claims and, on that basis, had identified an overpayment of \$164,193. WPS also noted that 1 of the 22 claims was eligible for a payment of \$1,650. Regarding the fact that our draft report had identified 28 improper payments, WPS stated that 6 of the payments were made correctly: 5 related to qualified clinical trials and the other payment involved a claim whose dates of service were prior to the Medicare Advantage enrollment effective date.

WPS’s comments are included in their entirety as the Appendix.

### **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing WPS’s written comments, we modified the relevant language in this final report. Although 22 of the 28 payments identified in our draft report were improper, we did not identify any evidence that WPS did not comply with Federal regulations. Specifically, we verified that 6 of the 28 improper payments identified in our draft report were in fact made correctly, and we revised our findings and recommendations accordingly. We also verified that the eligible payment of \$1,650 was in fact made correctly and that this amount is not included in the \$164,193 of improper payments identified in our finding.

# **APPENDIX**

## APPENDIX: AUDITEE COMMENTS



## Medicare

April 8, 2011

Mr. Patrick J. Cogley  
Regional Inspector General for Audit Services  
Office of Audit Services, Region VII  
601 East 12<sup>th</sup> Street  
Room 0429  
Kansas City, MO 64106

RE: Office of Inspector General (OIG) Draft Report -- A-07-10-01091

Dear Mr. Cogley,

This letter is in response to the OIG draft report titled *Review of Medicare Fee-for-Service Payments Made by Wisconsin Physicians Service Insurance Corporation for Medicare Advantage Enrollees During Calendar Years 2007 and 2008*.

OIG reviewed 150 Medicare Part A inpatient claims processed by Wisconsin Physicians Service (WPS) for Medicare Advantage (MA) enrollees, totaling \$1,596,893. Of these, 28 claims were identified as improper payments needing action, totaling \$245,545.

WPS disagrees with the OIG statement that *WPS did not always comply with Federal regulations in making Medicare FFS payments to hospitals for inpatient services furnished to Medicare Advantage enrollees*. As the OIG noted in the report, *WPS was not able to determine the beneficiaries' enrollment status on the CWF at the time it made these payments*. Additionally, in each of these cases *WPS did not receive an IUR from the CWF indicating that the beneficiary had been retroactively enrolled in an MA plan*. Approval was received for payment from CWF on each of these claims. None of them failed any edits related to MA enrollee status.

The CWF system does not display an audit history of changes. Thus the information to determine if the MA enrollment effective dates listed were prior to or after the claim processing dates was not available. If the MA enrollment effective dates were updated in CWF after the claim processing date, an Informational Unsolicited Response (IUR) was not received. WPS complied with Federal regulations in making these payments. Controls within CWF may not have been effective at the time these payments were made, but that does not indicate a lack of compliance with Federal regulations at WPS. As such, WPS respectfully requests that the OIG remove references to a WPS lack of compliance with Federal regulations when the final version of this report is released.

OIG Recommendations to WPS:

- *initiate overpayment recovery procedures to recoup \$245,545 of improper payments from providers,*
- *generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history, and*
- *reimburse the \$245,545 to the Federal Government*

WPS Response to the OIG Recommendations:

- *WPS should generate an adjustment to update or cancel the claims in order to update both the CWF and the contractor history*



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

- WPS has adjusted 22 of the identified claims for an overpayment of \$164,193.05. WPS has determined one of these 22 claims was eligible for an outlier payment in the amount of \$1,650.05. WPS has determined five of the identified claims were paid correctly as they related to qualifying Clinical Trials and per Internet-Only-Manual 100-04, Chapter 32, Section 69 are covered by Medicare (\$71,776.41 per the OIG). WPS has determined one of the identified claims was for dates of service prior to the MA enrollment effective date of January 1, 2008 as currently listed on CWF (\$7,925.97 per OIG).
- WPS should *initiate overpayment recovery procedures to recoup \$245,545 of improper payments from providers*
  - WPS has recovered \$140,027.69 to date of the \$164,193.05, noted above, from claim accounts receivables. WPS has reopened one cost report relating to a PIP provider with a claim overpayment amount of \$6,464.23 with only \$2.00 in overpayment recoverable via the revised settlement of PS&R data. There are two additional PIP providers with claim overpayments totaling \$17,701.13 (including \$15,129.77 which transitioned to Highmark Medicare Services on February 21, 2011) which will be included in the final cost report settlement when CMS sets the 2007 SSI ratios. The transitioning data was referred to the Kansas City Regional Office for their referral to Highmark Medicare Services for recovery. The contractors will not be able separate the recovery amounts for this report from the total final cost report settlement.
- WPS should *reimburse the \$245,545 to the Federal Government*
  - As indicated in the second bullet of the WPS response above, \$140,029.69 has been collected ~~... bullet about such recommendations prior to the release of the report in final as it is~~ redundant (i.e., the same as the first recommendation bullet).

In summary, prior to release of the OIG Final Report, WPS respectfully requests that the OIG remove any references to a WPS lack of compliance with Federal regulations as well as the third bullet from their recommendations, as it is duplicative of their first bullet.

If you have any questions or would like to set up a time for a conference call to discuss any issues identified in your report and/or the WPS response, please contact me at 402-351-6915.

Sincerely,



Mark DeFoil  
Director, Contract Coordination

cc: John Phelps, CMS  
Lisa Goschen, CMS  
Scott Englund, OIG