



May 24, 2011

**TO:** Donald M. Berwick, M.D.  
Administrator  
Centers for Medicare & Medicaid Services

**FROM:** /Diann M. Saltman/ for  
George M. Reeb  
Acting Deputy Inspector General for Audit Services

**SUBJECT:** Review of Medicare Payments Exceeding Charges for Outpatient Services  
Processed by Noridian Administrative Services, LLC, in Jurisdiction 3 for the  
Period January 1, 2006, Through June 30, 2009 (A-07-10-04163)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by Noridian Administrative Services, LLC (Noridian), in Jurisdiction 3. We will issue this report to Noridian within 5 business days.

If you have any questions or comments about this report, please do not hesitate to contact me at (410) 786-7104 or through email at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov), or Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at [Patrick.Cogley@oig.hhs.gov](mailto:Patrick.Cogley@oig.hhs.gov). Please refer to report number A-07-10-04163.

Attachment



Region VII  
601 East 12<sup>th</sup> Street  
Room 0429  
Kansas City, Missouri 64106

May 26, 2011

Report Number: A-07-10-04163

Mr. Michael Hamerlik  
President and Chief Executive Officer  
Noridian Administrative Services, LLC  
900 42nd Street South  
Fargo, ND 58103

Dear Mr. Hamerlik:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 3 for the Period January 1, 2006, Through June 30, 2009*. 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 Debra Keasling, Audit Manager, at (816) 426-3213 or through email at [Debra.Keasling@oig.hhs.gov](mailto:Debra.Keasling@oig.hhs.gov). Please refer to report number A-07-10-04163 in all correspondence.

Sincerely,

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

Enclosure

**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 PAYMENTS  
EXCEEDING CHARGES FOR  
OUTPATIENT SERVICES  
PROCESSED BY NORIDIAN  
ADMINISTRATIVE SERVICES, LLC,  
IN JURISDICTION 3  
FOR THE PERIOD JANUARY 1, 2006,  
THROUGH JUNE 30, 2009**



Daniel R. Levinson  
Inspector General

May 2011  
A-07-10-04163

# *Office of Inspector General*

<http://oig.hhs.gov>

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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 & 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.

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# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

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.

## **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 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 for outpatient services. 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 guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered. In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

Effective July 2006, Noridian Administrative Services, LLC (Noridian), became the Medicare contractor for Jurisdiction 3 in six States. During our audit period (January 2006 through June 2009), approximately 74.5 million line items for outpatient services were processed in Jurisdiction 3, of which 1,913 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000 and (2) 3 or more units of service. (A single Medicare claim from a provider typically includes more than one line item. In this audit we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges.")

### **OBJECTIVE**

Our objective was to determine whether certain Medicare payments in excess of charges that Noridian made to providers for outpatient services were correct.

### **SUMMARY OF FINDINGS**

Of the 1,913 selected line items for which Noridian made Medicare payments to providers for outpatient services during our audit period, 186 were correct. Providers refunded overpayments on 108 line items totaling \$2,173,056 prior to our fieldwork. The remaining 1,619 line items

were incorrect and included overpayments totaling \$5,778,429, which the providers had not refunded by the beginning of our audit.

Of the 1,619 incorrect line items:

- Providers reported incorrect units of service on 695 line items, resulting in overpayments totaling \$3,332,572.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes for 796 line items, resulting in overpayments totaling \$1,913,184.
- Providers used HCPCS codes that did not reflect the procedures performed for 108 line items, resulting in overpayments totaling \$437,131.
- Providers billed for unallowable services on 17 line items, resulting in overpayments totaling \$92,333.
- Providers could not provide the supporting documentation for three line items, resulting in overpayments totaling \$3,209.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

## **RECOMMENDATIONS**

We recommend that Noridian:

- recover the \$5,778,429 in identified overpayments,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

## **NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS**

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Our draft report included a fourth recommendation regarding the review and refund of 29 line items that were outstanding at the time of issuance of the report. For this recommendation, Noridian stated that it had reviewed the 29 line items and forwarded the results to us. Noridian's comments are included in their entirety as the Appendix.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

Providers have since adjusted the 29 line items that were outstanding at the time of issuance of our draft report and have consequently refunded an additional \$134,975 to Noridian. For this final report, we have revised our findings and our first recommendation to reflect the additional claim lines adjusted and amounts recovered, and we have removed the fourth recommendation, as it is no longer relevant.

# TABLE OF CONTENTS

|  | <u>Page</u> |
|--|-------------|
| <b>INTRODUCTION</b> .....  | 1           |
| <b>BACKGROUND</b> .....  | 1           |
| Medicare Contractors .....   | 1           |
| Claims for Outpatient Services .....   | 1           |
| Noridian Administrative Services, LLC .....  | 2           |
| <b>OBJECTIVE, SCOPE, AND METHODOLOGY</b> .....   | 2           |
| Objective .....  | 2           |
| Scope .....  | 2           |
| Methodology .....  | 2           |
| <b>FINDINGS AND RECOMMENDATIONS</b> .....  | 3           |
| <b>FEDERAL REQUIREMENTS</b> .....  | 4           |
| <b>OVERPAYMENTS FOR SELECTED LINE ITEMS</b> .....  | 4           |
| Incorrect Number of Units of Service .....   | 4           |
| Combination of Incorrect Number of Units of Service and<br>Incorrect Healthcare Common Procedure Coding System Codes ..... | 5           |
| Incorrect Healthcare Common Procedure Coding System Codes .....  | 5           |
| Services Not Allowable for Medicare Reimbursement .....  | 6           |
| Unsupported Services .....   | 6           |
| <b>CAUSES OF INCORRECT MEDICARE PAYMENTS</b> .....   | 6           |
| <b>RECOMMENDATIONS</b> .....   | 6           |
| <b>NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS</b> .....   | 7           |
| <b>OFFICE OF INSPECTOR GENERAL RESPONSE</b> .....  | 7           |
| <b>APPENDIX</b>  |             |
| <b>AUDITEE COMMENTS</b>  |             |

## INTRODUCTION

### BACKGROUND

Pursuant to Title XVIII of the Social Security 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 for outpatient services.<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 providers' outpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

#### Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail regarding each provided service (also known as the line item). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of units administered.<sup>2</sup> In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

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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. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

<sup>2</sup> HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

## **Noridian Administrative Services, LLC**

Effective July 2006, Noridian Administrative Services, LLC (Noridian), became the Medicare contractor for Jurisdiction 3 in six States: Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming.<sup>3</sup> During our audit period (January 2006 through June 2009), approximately 74.5 million line items for outpatient services were processed in Jurisdiction 3.

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

### **Objective**

Our objective was to determine whether certain Medicare payments in excess of charges that Noridian made to providers for outpatient services were correct.

### **Scope**

Of the approximately 74.5 million line items for outpatient services that Noridian processed during the period January 2006 through June 2009, 1,913 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000 and (2) 3 or more units of service.<sup>4</sup>

We limited our review of Noridian'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.

Our fieldwork included contacting Noridian, located in Fargo, North Dakota, and the 92 providers in Jurisdiction 3 that received the selected Medicare payments.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

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<sup>3</sup> Prior to July 31, 2006, providers processed Medicare outpatient claims through separate fiscal intermediaries. On July 31, 2006, Noridian became the Medicare contractor for these States and is therefore responsible for collecting any overpayments and resolving the issues related to this audit.

<sup>4</sup> A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges."

- used CMS’s National Claims History file to identify outpatient line items in which (1) Medicare line payment amounts exceeded the line billed charge amounts by at least \$1,000 and (2) the line had 3 or more units of service;<sup>5</sup>
- identified 1,913 line items totaling approximately \$9.6 million that Medicare paid to 92 providers;
- contacted the 92 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with Noridian; and
- discussed the results of our review with Noridian on January 24, 2011.

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 1,913 selected line items for which Noridian made Medicare payments to providers for outpatient services during our audit period, 186 were correct. Providers refunded overpayments on 108 line items totaling \$2,173,056 prior to our fieldwork. The remaining 1,619 line items were incorrect and included overpayments totaling \$5,778,429, which the providers had not refunded by the beginning of our audit.

Of the 1,619 incorrect line items:

- Providers reported incorrect units of service on 695 line items, resulting in overpayments totaling \$3,332,572.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes for 796 line items, resulting in overpayments totaling \$1,913,184.
- Providers used HCPCS codes that did not reflect the procedures performed for 108 line items, resulting in overpayments totaling \$437,131.

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<sup>5</sup> For this audit, we reviewed those line items that met the stated parameters. We applied these parameters to unadjusted line items. In some cases, subsequent payment adjustments reduced the difference between payments and charges to less than \$1,000.

- Providers billed for unallowable services on 17 line items, resulting in overpayments totaling \$92,333.
- Providers could not provide the supporting documentation for three line items, resulting in overpayments totaling \$3,209.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

## **FEDERAL REQUIREMENTS**

Section 1833(e) of the Social Security Act states: “No payment shall be made to any provider of services ... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid ....”

CMS’s *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: “providers must use HCPCS codes ... for most outpatient services.” Chapter 25, section 75.5, of the Manual states: “... when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.”<sup>6</sup> If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 ....”

Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

## **OVERPAYMENTS FOR SELECTED LINE ITEMS**

### **Incorrect Number of Units of Service**

Providers reported incorrect units of service on 695 line items, resulting in overpayments totaling \$3,332,572. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for 25 line items with the incorrect service units. Rather than billing between 7 and 8 service units (the correct range for the HCPCS codes associated with these line items), the provider billed between 70 and 80 service units. These errors occurred because the provider’s chargemaster<sup>7</sup> was incorrect. As a result of

<sup>6</sup> Prior to CMS Transmittal 1254, Change Request 5593, dated May 25, 2007, and effective June 11, 2007, this provision was located at chapter 25, section 60.5, of the Manual.

<sup>7</sup> A provider’s chargemaster contains data on every chargeable item or procedure that the provider offers.

these errors, Noridian paid the provider \$552,042 when it should have paid \$45,800, an overpayment of \$506,242.

- Another provider billed Medicare for five line items with incorrect service units. Rather than billing between 6 and 16 service units, the provider billed between 400 and 6,000 service units. These errors occurred because the provider's chargemaster was incorrect. As a result of these errors, Noridian paid the provider \$200,312 when it should have paid \$1,008, an overpayment of \$199,304.

### **Combination of Incorrect Number of Units of Service and Incorrect Healthcare Common Procedure Coding System Codes**

Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on 796 line items. These errors resulted in overpayments totaling \$1,913,184. For example, one provider incorrectly billed Medicare for 8 units of service for a 3.75 milligram (mg) dose of a drug used for various cancer treatments. The provider should have billed for 4 units of service for a 7.5 mg dose of this drug for use in the treatment of prostate cancer.<sup>8</sup> Similar errors occurred on a total of 331 line items submitted by this provider. As a result of these errors, Noridian paid the provider \$945,176 when it should have paid \$234,944, an overpayment of \$710,232.

### **Incorrect Healthcare Common Procedure Coding System Codes**

Providers used HCPCS codes that did not reflect the procedures performed for 108 line items, resulting in overpayments totaling \$437,131. The following examples illustrate the incorrect HCPCS codes used:

- One provider billed Medicare for nine line items with an HCPCS code for an injection of Galsulfase<sup>9</sup> rather than using the correct HCPCS code involving the administration of the chemotherapy agent Nelarabine, the procedure actually performed. As a result of these errors, Noridian paid the provider \$155,688 when it should have paid \$41,041, an overpayment of \$114,647.
- Another provider billed for 17 line items with an HCPCS code for a cancer treatment drug rather than using the correct HCPCS code involving the administration of a cancer treatment drug, the procedure actually performed. As a result of these errors, Noridian paid the provider \$55,861 when it should have paid \$149, an overpayment of \$55,712.

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<sup>8</sup> In this situation, there are two separate HCPCS codes for the same drug. The designation of correct dosage and units of service is based on the clinical indication that necessitates the drug use.

<sup>9</sup> Galsulfase is an enzyme that helps to decrease a substance in the body that can cause cell, tissue, and organ problems.

## **Services Not Allowable for Medicare Reimbursement**

Providers incorrectly billed Medicare for 17 line items for which the services rendered were not allowable for Medicare reimbursement, resulting in overpayments totaling \$92,333. As an example of the unallowable services, one provider billed Medicare for 15 line items that were unrelated to outpatient services. Specifically, the provider incorrectly billed Medicare outpatient services for dental procedures that are not covered by Medicare. For one such procedure, the provider billed for the extraction of a tooth, which is not a covered procedure according to the *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 150. As a result of these errors, Noridian paid the provider \$85,833 when it should have paid \$0, an overpayment of \$85,833.

## **Unsupported Services**

Two providers billed Medicare for three line items for which they could not provide supporting documentation. The providers agreed to cancel the claims associated with these line items and refund the \$3,209 overpayment that was received.

## **CAUSES OF INCORRECT MEDICARE PAYMENTS**

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.<sup>10</sup>

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires Medicare contractors to determine the legitimacy of the claims. However, this edit did not detect the errors that we found because the edit considers only the amount of the payment, suspends only those payments that exceed the threshold, and does not flag payments that exceed charges.

## **RECOMMENDATIONS**

We recommend that Noridian:

- recover the \$5,778,429 in identified overpayments,
- implement system edits that review line item payments that exceed billed charges by a prescribed amount, and

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<sup>10</sup> The Medicare contractor sends a *Medicare Summary Notice*—an explanation of benefits—to the beneficiary after the provider files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

- use the results of this audit in its provider education activities.

### **NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS**

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Our draft report included a fourth recommendation regarding the review and refund of 29 line items that were outstanding at the time of issuance of the report. For this recommendation, Noridian stated that it had reviewed the 29 line items and forwarded the results to us. Noridian's comments are included in their entirety as the Appendix.

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

Providers have since adjusted the 29 claim lines that were outstanding at the time of issuance of our draft report and have consequently refunded an additional \$134,975 to Noridian. For this final report, we have revised our findings and our first recommendation to reflect the additional claim lines adjusted and amounts recovered, and we have removed the fourth recommendation, as it is no longer relevant.

# **APPENDIX**

APPENDIX: AUDITEE COMMENTS



**Paul O'Donnell**  
Vice President  
Medicare Operations  
900 42nd Street South  
Fargo, ND 58103  
701-277-2401  
FAX: 701-277-5150  
paul.odonnell@noridian.com

February 25, 2011

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

RE: Report Number A-07-10-04163

Dear Mr. Cogley:

Thank you for the opportunity to respond to the draft report of the U.S. Department of Health & Human Services, Office of Inspector General (OIG) dated January 27, 2011, entitled, *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 3 for the Period of January 1, 2006, Through June 30, 2009*. We concur with the recommendations made by the OIG. Noridian Administrative Services, LLC (NAS) has provided our responses to these recommendations within the contents of this letter. Many of the action plans that NAS has planned to reduce future overpayments are contingent on the OIG providing NAS with a complete listing of the claims included in this audit. Without a complete listing NAS will be unable to perform data analysis and prioritize the specific aberrancies for correction. The NAS actions will be an ongoing effort due to the extent of activities planned and the time that can be associated with the research, development, testing and implementation of certain initiatives.

Upon receipt of the audit claims data we will review the CPT/HCPC codes identified in this audit and determine which codes are now included on the published Medical Unlikely Edits (MUE) listing and have unit of service limits. These MUE's are also edits in the standard Part A system, FISS, and should assist in minimizing unit of service overpayments in the future. For those codes not included in either the published or non-published MUE listings, NAS will explain our initiatives/plans to reduce future overpayments in the response below.

It is important to note that future overpayments may still be possible even after NAS has completed our plans of action due to the fact that Medicare contractors are not funded to

perform 100% complex review of claims. Without a comparison of medical records and coding on 100% of claims billed, there is the potential for overpayments (and underpayments) resulting from billing incorrect procedure codes, units of service and other claims payment indicators. NAS will do all we can within our scope and funding to reduce overpayments. An important tool or step in this process that NAS has considered is to make referrals to the Program Safeguard Contractor (PSC), Recover Audit Contractors (RAC) and CMS as a method of business collaboration.

#### **OIG RECOMMENDATIONS:**

- **Recover the \$5,643,454 in identified overpayments**  
NAS Response: NAS concurs with the recommendation that all overpayments identified are to be collected. NAS has completed collections of these overpayments either by provider refund check or adjustment made by the provider. No further action is required.
  
- **Determine the amount of overpayment for the 29 incorrect line item payments and recover that amount**  
NAS Response: NAS reviewed the 29 line items and forwarded results to the OIG on January 25, 2011. Our understanding was that the OIG was going to review to determine what next steps will be taken.
  
- **Implement system edits that review line item payments that exceed billed charges by a prescribed amount**  
NAS Response: NAS has established an Outpatient Assessment Task Force (OATF) of seasoned Medicare staff that will be reviewing the claims data from the OIG's audit. Team Members include: Contractor Medical Director (CMD), CMD Assistant (RN), Medical Review Manager (RN) and/or Team Leader (RN), Part A Claims Manager and/or Team Leader and Part A Systems Manager and/or Team Leader and others as needed. The OATF will perform the following activities and as much as possible utilize the already established (and funded) processes and procedures within the current NAS Medicare infrastructure:
  - NAS will write a User Project Action Request (PAR) and submit to the data center to assess the feasibility of creating a national FISS edit that would address line item payments exceeding billed charges. If the request is not a feasible option NAS will evaluate if user controlled edits in FISS would be a viable option. NAS' preference would be to have the FISS maintainer and CMS support to implement a national system edit in FISS.
  - To establish a priority ranking for implementing potential actions, NAS will utilize the specific data from this audit for the assessment of:
    - overpayments dollars per claim (highest to lowest)

- units billed (highest to lowest)
  - most frequently billed codes (highest to lowest)
  - specific providers included in this audit (highest claim volume to lowest)
  - Perform a review of unallowable services and determine if a User PAR should be created to submit to the data center for a standard system edit. This would be the best solution for many of these codes so the correction would be applicable for all Part A Medicare contractors. If not possible, consider local edits as appropriate.
  - Perform a review of unit of services allowed and determine if a User PAR should be created to submit to the data center for a standard system edit. If not possible, consider local edits as appropriate. NAS would consider returning the claim to the provider (RTP) to verify if the units billed are accurate.
  - As appropriate, the CMD will assess if a new Local Coverage Determination (LCD) is warranted or changes to any existing LCD's are needed.
  - Assess high overpayment codes in addition to the annual Medical Review Strategy (which would result in claims to be reviewed at the complex level by Medical Review nurses)
  - Refer recommendations for post-pay reviews to the Recovery Audit Contractor (RAC) per the new CMS direction from TDL dated 2/17/11.
  - As appropriate refer recommendations to the PSC.
  - NAS' two CMD's are members of the National MUE workgroup committee and as appropriate will elevate problematic codes to the committee for review and consideration of new MUE edits.
- **Use the results of this audit in its provider education activities**  
NAS Response: NAS has several plans of action that will include various methods of provider education. The OATF will update the Provider Outreach and Education team with specific education topics as they relate to the data assessed. NAS plans the following provider education activities:
    - Develop provider training on the 'hot spots' identified through assessments.
    - Develop tools/resources on our website as a resource for providers.
    - 30 minute online provider education sessions (as applicable).
    - Provider education articles that will be distributed via the list-serv and posted to the NAS website.
    - Providers with an error rate of \$5,000 and above will be educated on an individual basis and the provider will be required to submit a corrective action plan to NAS.

Please advise if additional information or further clarification is needed on any of our response. Please contact Paul O'Donnell, Medicare Operations Vice President, at (701) 277-2401 or through email at [Paul.O'Donnell@noridian.com](mailto:Paul.O'Donnell@noridian.com)

Sincerely,

*/s/ Paul O'Donnell*

Paul O'Donnell  
Vice President  
Noridian Administrative Services, LLC