



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201



July 12, 2012

**TO:** Marilyn Tavenner  
Acting Administrator  
Centers for Medicare & Medicaid Services

**FROM:** /Gloria L. Jarmon/  
Deputy Inspector General for Audit Services

**SUBJECT:** Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation in Jurisdiction 5 for the Period January 1, 2006, Through June 30, 2009 (A-07-11-04174)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by Wisconsin Physicians Service Insurance Corporation (WPS) in Jurisdiction 5. We will issue this report to WPS within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at [Brian.Ritchie@oig.hhs.gov](mailto:Brian.Ritchie@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-07-11-04174.

Attachment



DEPARTMENT OF HEALTH AND HUMAN SERVICES

## OFFICE OF INSPECTOR GENERAL



OFFICE OF AUDIT SERVICES, REGION VII  
601 EAST 12<sup>TH</sup> STREET, ROOM 0429  
KANSAS CITY, MO 64106

July 18, 2012

Report Number: A-07-11-04174

Ms. Jared A. Adair  
Senior Vice President, Medicare Operations  
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 and Human Services, Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation in Jurisdiction 5 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-07-11-04174 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 355  
Kansas City, MO 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS EXCEEDING  
CHARGES FOR OUTPATIENT SERVICES  
PROCESSED BY WISCONSIN PHYSICIANS SERVICE  
INSURANCE CORPORATION IN JURISDICTION 5  
FOR THE PERIOD JANUARY 1, 2006,  
THROUGH JUNE 30, 2009**



Daniel R. Levinson  
Inspector General

July 2012  
A-07-11-04174

# *Office of Inspector General*

<http://oig.hhs.gov>

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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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## EXECUTIVE SUMMARY

### BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with 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 details 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 billable units administered, as defined by the HCPCS code description. 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.

Prior to Medicare contracting reform, Wisconsin Physicians Service Insurance Corporation (WPS) processed claims for hospitals and other institutional providers from all 15 jurisdictions. This workload is referred to as the Legacy Workload. As part of Medicare contracting reform, CMS is transitioning the Legacy Workload to Medicare contractors, but during the transition period WPS continues to process most of the Legacy Workload. In addition, with the implementation of Medicare contracting reform, WPS became the Medicare contractor for Jurisdiction 5 in four States—Iowa, Kansas, Missouri, and Nebraska—and assumed full responsibility for Jurisdiction 5 in June 2008.

For this audit, we reviewed outpatient claims from both the Legacy and Jurisdiction 5 Workloads. (For purposes of this report, we refer to claims from the Legacy and Jurisdiction 5 Workloads as "Jurisdiction 5.") During our audit period (January 2006 through June 2009), WPS processed approximately 322.2 million line items for outpatient services in Jurisdiction 5, of which 2,200 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 criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges.") We reviewed only 2,197 of the 2,200 line items because 2 providers associated with 3 line items were either no longer in business or in bankruptcy.

## **OBJECTIVE**

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

## **SUMMARY OF FINDINGS**

Of the 2,197 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 536 were correct. Providers refunded overpayments on 52 line items totaling \$525,919 before our fieldwork. The remaining 1,609 line items were incorrect and included overpayments totaling \$6,159,765, which the providers had not refunded by the beginning of our audit. As of June 4, 2012, the amount of overpayment for one remaining incorrect line item had not been determined because the line item had not been reprocessed and the correct line payment amount had not been identified.

Of the 1,609 incorrect line items:

- Providers reported incorrect units of service on 1,182 line items, resulting in overpayments totaling at least \$4,411,569 (the amount of overpayment for 1 of the 1,182 line items had not been determined).
- Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on 240 line items, resulting in overpayments totaling \$1,096,995.
- Providers billed for unallowable services on 82 line items, resulting in overpayments totaling \$279,838.
- Providers used HCPCS codes that did not reflect the procedures performed on 67 line items, resulting in overpayments totaling \$261,876.
- Providers did not provide the supporting documentation for 38 line items, resulting in overpayments totaling \$109,487.

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. WPS 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 WPS:

- recover the \$6,159,765 in identified overpayments,

- determine the amount of overpayment for the one incorrect line item payment and recover that amount,
- work with CMS to 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.

## **WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS**

In written comments on our draft report, WPS generally concurred with our recommendations. With respect to our first recommendation, WPS stated that it determined the claim level overpayment amount on the incorrect lines to be approximately \$6,098,149. Because WPS provided the claim level overpayment amount as opposed to the line item overpayment, additional line items that we did not review were included in WPS's overpayment amount; these additional items represent \$155,473 more than the amount that our draft report had recommended for recovery.

Our draft report included a recommendation related to the recovery of 48 incorrect line item payments whose line payment amounts had not been determined. In comments on this recommendation, WPS stated that it had determined the overpayments on 42 of the incorrect lines, with 4 claims still in processing. One claim could not be adjusted as it was no longer accessible in the Fiscal Intermediary Standard System. In comments on the last two recommendations, WPS described corrective actions that it had taken or planned to take.

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

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

When we issued our draft report, 48 of the 1,609 incorrect line items had not been reprocessed, and the correct line payment amounts for these 48 line items had not been determined. After submitting its written comments, WPS provided us with additional information supporting that it had collected an additional \$217,089 associated with 47 of the 48 remaining line items. One claim had not been reprocessed, and the correct line payment amount had not been identified. For this final report, we revised our findings and first two recommendations to reflect the additional claim lines adjusted and amounts recovered. Thus, the amount recommended for recovery was increased from \$5,942,676 in the draft report to \$6,159,765 in this final report to reflect the additional \$217,089 in recoveries associated with the 47 line items.



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# INTRODUCTION

## BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services.

### Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B 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 details 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 billable units administered, as defined by the HCPCS code description.<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.

## **Wisconsin Physicians Service Insurance Corporation**

Prior to Medicare contracting reform, Wisconsin Physicians Service Insurance Corporation (WPS) processed claims for hospitals and other institutional providers from all 15 jurisdictions. This workload is referred to as the Legacy Workload.<sup>3</sup> As part of Medicare contracting reform, CMS is transitioning the Legacy Workload to Medicare contractors, but during the transition period WPS continues to process most of the Legacy Workload.<sup>4</sup> In addition, with the implementation of Medicare contracting reform, WPS became the Medicare contractor for Jurisdiction 5 in four States—Iowa, Kansas, Missouri, and Nebraska—and assumed full responsibility for Jurisdiction 5 in June 2008.

For this audit, we reviewed outpatient claims from both the Legacy and Jurisdiction 5 Workloads. (For purposes of this report, we refer to claims from the Legacy and Jurisdiction 5 Workloads as “Jurisdiction 5.”) During our audit period (January 2006 through June 2009), WPS processed approximately 322.2 million line items for outpatient services in Jurisdiction 5.

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

#### **Objective**

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

#### **Scope**

Of the approximately 322.2 million line items for outpatient services that WPS processed during the period January 2006 through June 2009, 2,200 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>5</sup> We reviewed only 2,197 of the 2,200 line items because 2 providers associated with 3 line items were either no longer in business or in bankruptcy.

We limited our review of WPS’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

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<sup>3</sup> The WPS Legacy workload had previously been processed by Mutual of Omaha. The Legacy Workload includes claims submitted by providers who fall under the geographic jurisdiction of all 15 MACs.

<sup>4</sup> The Legacy Workload transition to Jurisdiction 1 occurred on April 19, 2010, and will be separately reported in audit report A-07-11-04182. The Legacy Workload transition to Jurisdiction 4 occurred on October 18, 2010, and will be separately reported in audit report A-07-11-04183. The Legacy Workload transition to Jurisdiction 12 occurred on February 21, 2011, and will be separately reported in audit report A-07-11-04184.

<sup>5</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.”

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 WPS in Omaha, Nebraska, and the 242 providers in Jurisdiction 5 that received the selected Medicare payments.

## **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items processed by WPS for providers that billed line items with (1) a Medicare line payment amount that exceeded the line billed charge amounts by at least \$1,000 and (2) 3 or more units of service;<sup>6</sup>
- identified 2,197 line items totaling approximately \$9.4 million that Medicare paid to 242 providers;
- contacted the 242 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 WPS and the providers; and
- provided the results of our review to WPS officials on October 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 2,197 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 536 were correct. Providers refunded overpayments on 52 line items totaling \$525,919 prior to our fieldwork. The remaining 1,609 line items were

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<sup>6</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.

incorrect and included overpayments totaling \$6,159,765, which the providers had not refunded by the beginning of our audit. As of June 4, 2012, the amount of overpayment for one remaining incorrect line item had not been determined because the line item had not been reprocessed and the correct line payment amount had not been identified.

Of the 1,609 incorrect line items:

- Providers reported incorrect units of service on 1,182 line items, resulting in overpayments totaling at least \$4,411,569 (the amount of overpayment for 1 of the 1,182 line items had not been determined).
- Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on 240 line items, resulting in overpayments totaling \$1,096,995.
- Providers billed for unallowable services on 82 line items, resulting in overpayments totaling \$279,838.
- Providers used HCPCS codes that did not reflect the procedures performed on 67 line items, resulting in overpayments totaling \$261,876.
- Providers did not provide the supporting documentation for 38 line items, resulting in overpayments totaling \$109,487.

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. WPS 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>7</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

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<sup>7</sup> Before 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.

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 an incorrect number of units of service on 1,182 line items, resulting in overpayments totaling at least \$4,411,569. (The amount of overpayment for 1 of the 1,182 line items had not been determined as of June 4, 2012, because the line item had not been reprocessed, and the correct line payment amount had not been identified.) The following examples illustrate the incorrect units of service:

- One provider billed Medicare for an incorrect number of service units on 114 line items. Rather than billing 32 service units, the provider billed between 640 and 656 service units. These errors occurred because of an error in the provider’s billing system. As a result of these errors, WPS paid the provider \$219,518 when it should have paid \$10,097, an overpayment of \$209,421.
- Another provider billed Medicare for an incorrect number of service units on 72 line items. Rather than billing between 1 and 3 service units (the correct range for the HCPCS codes associated with these line items), the provider billed between 42 and 45 service units. These errors occurred because the provider’s chargemaster<sup>8</sup> was incorrect. As a result of these errors, WPS paid the provider \$178,308 when it should have paid \$7,941, an overpayment of \$170,367.

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

Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on 240 line items. These errors resulted in overpayments totaling \$1,096,995.

For example, one provider incorrectly billed Medicare for 106 service units of an injection of clonidine hydrochloride with a HCPCS code of J0735 rather than billing for 1 service unit of unclassified drugs with a HCPCS code of J3490. As a result of this error, WPS paid the provider \$230,987 when it should have paid \$0. The provider refunded the entire incorrect payment of \$230,987.

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

Providers incorrectly billed Medicare for 82 line items for which the services rendered were not allowable for Medicare reimbursement, resulting in overpayments totaling \$279,838.

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<sup>8</sup> A provider’s chargemaster contains data on every chargeable item or procedure that the provider offers.

For example, 1 provider billed Medicare for 18 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 surgical removal of an erupted 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, WPS paid the provider \$53,197 when it should have paid \$0, an overpayment of \$53,197.

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

Providers used HCPCS codes that did not reflect the procedures performed on 67 line items, resulting in overpayments totaling \$261,876.

For example, because of an error in the chargemaster, one provider billed Medicare for 31 line items with the HCPCS code P9045 for a 250-milliliter (ml) infusion of the protein albumin, rather than using the correct HCPCS code (P9041) for the 50-ml infusion of albumin that was actually administered. As a result of this error, WPS paid the provider \$132,744 when it should have paid \$37,415, an overpayment of \$95,329.

### **Unsupported Services**

Thirteen providers billed Medicare for 38 line items for which they did not provide supporting documentation. The providers agreed to cancel the claims associated with these line items and refund the combined \$109,487 of overpayments 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. WPS 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>9</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.

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<sup>9</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.

## **RECOMMENDATIONS**

We recommend that WPS:

- recover the \$6,159,765 in identified overpayments,
- determine the amount of overpayment for the one incorrect line item payment and recover that amount,
- work with CMS to 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.

## **WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS**

In written comments on our draft report, WPS generally concurred with our recommendations. With respect to our first recommendation, WPS stated that it determined the claim level overpayment amount on the incorrect lines to be approximately \$6,098,149. Because WPS provided the claim level overpayment amount as opposed to the line item overpayment, additional line items that we did not review were included in WPS's overpayment amount; these additional items represent \$155,473 more than the amount that our draft report had recommended for recovery.

Our draft report included a recommendation related to the recovery of 48 incorrect line item payments whose line payment amounts had not been determined. In comments on this recommendation, WPS stated that it had determined the overpayments on 42 of the incorrect lines, with 4 claims still in processing. One claim could not be adjusted as it was no longer accessible in the Fiscal Intermediary Standard System. In comments on the last two recommendations, WPS described corrective actions that it had taken or planned to take.

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

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

When we issued our draft report, 48 of the 1,609 incorrect line items had not been reprocessed, and the correct line payment amounts for these 48 line items had not been determined. After submitting its written comments, WPS provided us with additional information supporting that it had collected an additional \$217,089 associated with 47 of the 48 remaining line items. One claim had not been reprocessed, and the correct line payment amount had not been identified. For this final report, we revised our findings and first two recommendations to reflect the additional claim lines adjusted and amounts recovered. Thus, the amount recommended for recovery was increased from \$5,942,676 in the draft report to \$6,159,765 in this final report to reflect the additional \$217,089 in recoveries associated with the 47 line items.



# **APPENDIX**

**APPENDIX: WISCONSIN PHYSICIANS SERVICE  
INSURANCE CORPORATION COMMENTS**



**Medicare**

May 16, 2012

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-07-11-04174

Dear Mr. Cogley,

This letter is in response to the OIG draft report titled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation in Jurisdiction 5 for the Period January 1, 2006, Through June 30, 2009.*

OIG reviewed 2,197 data lines from Medicare Part A outpatient claims processed by Wisconsin Physicians Service (WPS). Of these, 1,561 lines from claims included overpayments totaling \$5,942,676. An additional 48 incorrect lines had not been determined because the line items had not been reprocessed and the correct line payment amounts had not been identified.

The OIG report stated *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, WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.*

OIG Recommendations to WPS:

- *recover the \$5,942,676 in identified overpayments,*
- *determine the amount of overpayment for the 48 incorrect line item payments and recover that amount,*
- *work with CMS to 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.*

WPS Response to the OIG Recommendations:

- WPS should *recover the \$5,942,676 in identified overpayments*
  - WPS has determined the claim level overpayment amount relating to the 1561 identified lines to be approximately \$6,098,149. A few claims are still being researched and the recovery of the overpayment is currently under way. The difference in the overpayment amounts is due mainly to the impact of other lines on the claim and differences in actual line level reimbursement (example: the provider cancelled the claim and the identified amount relates to the portion relating to the line being cancelled).



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- WPS should *determine the amount of overpayment for the 48 incorrect line item payments and recover that amount*
  - WPS currently has determined the overpayment on 42 of the incorrect lines for a claim level overpayment of \$196,561.51 with four claims still processing. There is one claim with date of service in 2007 which can not be adjusted as it is no longer accessible in FISS.
- WPS should *work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount*
  - CMS issued Change Request 7771; *New Fiscal Intermediary Shared System (FISS) Edit to Review Medicare Outpatient Prospective Payment System (OPPS) Payments Exceeding Charges*, on April 27, 2012, to be effective on claims received on or after October 1, 2012.
- WPS should *use the results of this audit in its provider education activities*
  - Currently, Part A Outreach educates hospital providers on the correct reporting of CPT/HCPCS codes and units of service. We state these are critical billing elements that must be reported correctly in order for the claim to process and pay accurately. As an additional note, we advise the provider that reporting units accurately ensures correct payment, and incorrect reporting of units may result in significant underpayments or overpayments and require a claim adjustment when and if the error is found.
  - In the future, Part A Outreach will include specific education on the items noted in the OIG report when conducting applicable educational events - such as Outpatient Hospital seminars.

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 402-995-0443.

Sincerely,



Mark DeFoil

Director, Contract Coordination

cc: John Phelps, CMS  
Lisa Goschen, CMS  
Joni Jones, CMS  
Pamela Bragg, CMS  
Debra Keasling, OIG