Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

July 2, 2002

Common Identification Number: A-02-01-01026

Mr. William Foley
Vice President, Medicare Operations
Empire Medicare Services
2651 Strang Boulevard
Yorktown Heights, NY 10598

Dear Mr. Foley:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Fiscal Year 2001 Medicare Error Rate at Empire Medicare Services." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to Common Identification Number A-02-01-01026 in all correspondence relating to this report.

Sincerely yours,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
Mr. Joseph Tilghman, Acting Regional Administrator, CMS

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF FISCAL YEAR 2001 MEDICARE ERROR RATE AT EMPIRE MEDICARE SERVICES

JANET REHNQUIST
INSPECTOR GENERAL

JULY 2002
A-02-01-01026

Office of Inspector General

http://oig.hhs.gov/

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.

Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
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New York, NY 10278

July 2, 2002

Our Reference: Common Identification No. A-02-01-01026

Mr. William Foley
Vice President, Medicare Operations
Empire Medicare Services
2651 Strang Boulevard
Yorktown Heights, New York 10598

Dear Mr. Foley:

This report provides you with the results of our "REVIEW OF FISCAL YEAR 2001 MEDICARE ERROR RATE AT EMPIRE MEDICARE SERVICES". The review was required by the Chief Financial Officers (CFO) Act of 1990, as amended.

The objective of this aspect of the review was to assess claims processing operations at Empire Medicare Services (Empire) that contributed to the preparation of the fiscal year (FY) 2001 combined financial statements for the Centers for Medicare & Medicaid Services (CMS). A separate report (CIN A-02-01-01022) has been issued on the CFO review of accounting controls and financial activity at Empire. Both audits evaluated the controls and operations at Empire for the second and third quarters of 2001, January 1 through March 31, 2001 and April 1 through June 30, 2001, respectively.

This review identified claims processing matters that require corrective actions in order to comply with applicable laws and regulations and prevent material misstatement of the CMS financial statements. Specifically, our review of 1,661 sample claims identified 163 claims that did not comply with Medicare laws and regulations. These errors were detected through medical review of supporting documentation and detailed testing by the Office of Inspector General (OIG) auditors. Contributing significantly to the errors noted during the course of the review was the fact that provider records did not completely and accurately support amounts reimbursed by Medicare.

We are recommending that Empire (1) recover and/or refund improper payments totaling $82,627.75 for the sample claims and (2) reinforce certain requirements through provider bulletins and other provider education opportunities to assure compliance with Medicare guidelines.

Empire concurred with the recommendations and noted that corrective actions have been initiated with respect to the reported findings. The full text of Empire's response is attached as an Appendix to this report.

INTRODUCTION

Background

Medicare was established under Title XVIII of the Social Security Act by the Social Security Amendments of 1965. At the Federal level, Medicare is administered by CMS. To accomplish its mission, CMS contracts with fiscal intermediaries (FIs) and carriers to process Medicare claims submitted by health care providers. The CMS instructions to FIs and carriers are included in the Medicare Intermediary Manual and the Medicare Carriers Manual, respectively.

Under contract with CMS, Empire is an FI and carrier that processes Medicare claims for providers located in New York State, New Jersey, Massachusetts, Delaware and Connecticut. As such, Empire is responsible for pricing covered medical items and services, making claims payments, guarding against the unnecessary use of medical services, and reporting financial activity to CMS. Medicare claims are processed by Empire using the Fiscal Intermediary Shared System for the FI and the Viable Information Processing Systems' (ViPS) Medicare System and the Multiple Carrier System for the carriers. During FY 2001, Empire reported processing 12,208,220 Medicare Part A claims totaling $12,556,098,749 and 63,715,023 Medicare Part B claims totaling $4,922,884,875.

Objectives, Scope and Methodology

The objective of the review was to assess claims processing operations at Empire that contributed to the preparation of the FY 2001 combined financial statements for CMS. The audit scope included reviews of the controls and operations related to the claims processing operations at Empire for the second and third quarters of FY 2001. For the second quarter of FY 2001, Empire reported processing 3,199,984 Medicare Part A claims totaling $2,929,722,036 and 15,662,913 Medicare Part B claims totaling $1,089,485,597. For the third quarter of FY 2001, Empire reported processing 3,398,154 Medicare Part A claims totaling $3,135,286,440 and 16,670,600 Medicare Part B claims totaling $1,309,500,742.

After reconciling the monthly CMS financial filings to Empire's paid claims tapes, we selected a sample of 50 Medicare beneficiaries for detailed testing for each of the sampled quarters. The second quarter sample consisted of 809 claims totaling $623,942.85 and the third quarter sample consisted of 852 claims totaling $706,976.39. Our auditors then tested the sampled claims to assure beneficiary and provider eligibility, timely filing and the propriety of deductible, coinsurance and provider reimbursement amounts. This phase of the review also included tests to ensure that Medicare only paid

for allowable services, had not issued duplicate payments and only paid a secondary benefit when other primary coverage existed.

In addition to the tests performed by our staff, medical review of sampled hospital inpatient claims was performed by the Island Peer Review Organization (IPRO), Quality Insights of Delaware (QID) and Qualidigm, the Peer Review Organizations (PROs) for the States of New York, Delaware, and Connecticut, respectively. Medical review for all other sample claims was performed by Empire's medical review staff.

Field work was performed during the period June through December 2001 at Empire's New York offices in Syracuse, Yorktown Heights and New York City and at their office in Harrisburg, Pennsylvania. This audit was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The review identified certain matters that require corrective actions in order to comply with applicable laws and regulations and prevent material misstatement of the CMS financial statements. Specifically, 163 of the 1,661 claims reviewed did not comply with Medicare laws and regulations. Most of these errors could only be detected through review of the supporting medical records and were found to be in error as detailed below:

Error Category	2nd Qtr Error Claims	3rd Qtr Error Claims	Grand Total
No Documentation	4	2	6
Insufficient Documentation	6	7	13
Medically Unnecessary Service	2	0	2
Services Incorrectly Coded	62	47	109
Services Not Covered	0	1	1
Services Provided by Someone Other than Billing	1	1	2
Services Billed Were Not Rendered	5	7	12
Duplicate Payment	5	3	8
Unbundling	1	5	6
Utilization	2	1	3
Invalid Inpatient Admission	2	2	4
Other Errors	1	2	3
Total Claim Error Lines	91	78	169
Less Claims with Multiple Error Lines	4	2	6
Total Error Claims	87	76	163

Specific details regarding the errors identified by the review were provided to Empire officials during the exit conference held on February 7, 2002 to facilitate timely recoupment of the overpayments and refund of the underpayments.

REVIEW OF CLAIMS PROCESSING CONTROLS

The Medicare Program requires that medical services must be reasonable, medically necessary, and delivered in the appropriate setting. In addition, Title 42 Code of Federal Regulations, Section 482.24 (c) requires providers to maintain medical records that contain sufficient documentation to substantiate the nature and/or necessity of services furnished, diagnoses, treatments performed, continued care and inpatient admissions.

Our review indicates that 163 of the 1,661 claims reviewed did not comply with Medicare laws and regulations. The improper payments for these claims amounted to $82,627.75, or 6.2% of the total payments of $1,330,919.24 included in the sample, as noted below:

	Second Quarter Review			Third Quarter Review			Total		
	# of Claims Reviewed	# of Error Claims	Improper Payment	# of Claims Reviewed	# of Error Claims	Improper Payment	# of Claims Reviewed	# of Error Claims	Improper Payment
Claims Processed by Fiscal Intermediary:									
Claims Reviewed by Empire – Syracuse	96	7	$ 1,285.16	104	9	$12,579.66	200	16	$13,864.82
Inpatient Claims Reviewed by IPRO	31	5	32,854.26	26	3	15,176.10	57	8	48,030.36
Inpatient Claims Reviewed by Quality Insights	2	0	0.00	1	0	0.00	3	0	0.00
Inpatient Claims Reviewed by Qualidigm	1	0	0.00	5	1	(912.52)	6	1	(912.52)
Additional Testing by OIG Auditors		2	19.30		2	14,807.98		4	14,827.28
Claims Processed by Carrier:									
Claims Reviewed by Empire - Yorktown Heights	540	46	1,988.19	614	45	2,631.36	1,154	91	4,619.55
Claims Reviewed by Empire – Harrisburg	139	26	1,191.43	102	13	459.80	241	39	1,651.23
Additional Testing by OIG Auditors		1	8.25		3	538.78		4	547.03
Totals	809	87	$37,346.59	852	76	$45,281.16	1,661	163	$82,627.75

REVIEW OF CLAIMS PROCESSED BY THE FISCAL INTERMEDIARY

Claims Reviewed by Empire's Medical Review staff – Empire's fiscal intermediary personnel conducted medical reviews of 200 sample claims, consisting of 171 hospital outpatient and 29 skilled nursing facility (SNF) claims. Through their review of the supporting medical records, Empire identified 16 claims totaling $13,864.82 which had been improperly paid as follows:

Error Category	2nd Qtr		3rd Qtr		Totals	
	# Claims	Error Amt.	# Claims	Error Amt.	# Claims	Error Amt.
Insufficient Documentation	3	$769.30	5	$12,419.62	8	$13,188.92
Medically Unnecessary Service	1	485.26	0	0.00	1	485.26
Services Incorrectly Coded	1	18.53	2	86.13	3	104.66
Services Not Rendered	1	0.00	2	73.91	3	73.91
Duplicate Payment	1	12.07	0	0.00	1	12.07
Totals	7	$1,285.16	9	$12,579.66	16	$13,864.82

To illustrate, Empire's medical review staff identified the following situations:

- **Insufficient Documentation** - A SNF was reimbursed $6,368.44 for a post-hospital stay. Medicare payments for SNF residents are based on the patient's clinical status at the most recent "assessment reference date" (ARD). The ARD on the records for this claim, however, appears to have been altered with no explanation as to when or why the change was made. The medical reviewer concluded that because the ARD was altered, the documentation was insufficient to reach an informed medical decision as to the accuracy or propriety of the claim. Therefore, the medical reviewer denied the entire payment of $6,368.44.

- **Medically Unnecessary Service** - A SNF was paid $538.05 for physical therapy and radiology services. The medical reviewer determined from the medical records that the initial evaluation for physical therapy (one year prior) and current evaluation show the same functional abilities and no improvement. The plan of treatment, too, did not support the need for skilled physical therapy after one year of services. As a result, the reviewer determined that the physical therapy services were medically unnecessary. The provider's claim for reimbursement was adjusted by $485.26 for the unallowable physical therapy services.

- **Services Incorrectly Coded** - A physician was paid $104.46 for a thyroxine test and for a panel of tests which includes thyroid stimulation hormone (TSH) testing. The medical reviewer determined that only the thyroxine and TSH tests were ordered and performed. As a result, the provider's claim for reimbursement was adjusted by $68.79.

Recommendations

We recommend that Empire recover and/or refund the improper payments totaling $13,864.82, as detailed above. We also recommend that Empire issue reminders, through its provider bulletins, of the need to properly document the medical records in order to avoid problems such as those cited above.

Hospital Inpatient Claims Reviewed by the PROs – Section 1154 of the Social Security Act and Section 1010 of the PRO Manual requires PROs to monitor services provided to Medicare beneficiaries. Medical review by the PROs of 66 sample claims resulted in disallowances totaling $47,117.84 for nine claims. The following chart details the errors identified by the medical review staff of the PROs.

Error Category	2nd Qtr		3rd Qtr		Totals	
	# Claims	Error Amt.	# Claims	Error Amt.	# Claims	Error Amt.
Medically Unnecessary Service	1	$ 7,297.80	0	$ 0.00	1	$ 7,297.80
Services Incorrectly Coded	0	0.00	1	(912.52)	1	(912.52)
Utilization	2	16,583.76	1	4,800.60	3	21,384.36
Invalid Inpatient Admission	2	8,972.70	2	10,375.50	4	19,348.20
Totals	5	$32,854.26	4	$14,263.58	9	$47,117.84

Examples of errors detected during the PROs' medical review are as follows:

- **Utilization** - A hospital was reimbursed $4,800.60 for acute inpatient rehabilitation services. The medical reviewer determined that while the services were medically necessary, the documentation did not support therapy for at least three hours daily. Medicare guidelines, however, require that the patient receive at least three hours of therapy per day for rehabilitation services in this setting. As a result, the provider's $4,800.60 claim for reimbursement was denied.

- **Invalid Inpatient Admission** - An acute care hospital was reimbursed $2,527.69 for a patient who was admitted with persistent hip pain after a fall. According to the PRO's medical reviewers, the records indicated no fracture or dislocation. The reviewers also found that the patient received oral medication, physical therapy and social services which did not require or indicate an acute level of care. Therefore, the provider's $2,527.69 claim for reimbursement was denied.

Recommendations

We recommend that Empire recover and/or refund the improper payments totaling $47,117.84 for the sample claims. We also recommend that Empire issue reminders, through its provider bulletins, of the need to properly evaluate the necessity of services in inpatient hospital settings in order to avoid problems such as those cited above.

Additional testing by OIG Auditors – Detailed testing of FI claims by OIG auditors identified four additional claims totaling $14,827.28 which were denied for various reasons as illustrated by the example below.

- **Other Errors** - A hospital billed Medicare $45,909.00, and was paid $16,367.02, for services rendered during an inpatient stay. Since the patient had exhausted the inpatient benefits available under Part A, payment was made for Medicare Part B services under the outpatient prospective payment system. The hospital was paid

for radiology and diagnostic laboratory services as well as three hemodialysis treatments. The provider billed Medicare $425.00 for two of the hemodialysis treatments, but mistakenly billed $42,500.00 for the third treatment. As a result of our request for medical and billing records, the provider acknowledged that the amount billed for the third treatment was overstated and indicated that a correction would be made. The abnormally high charge for this hemodialysis treatment resulted in an improper outlier payment. Therefore, the $14,807.98 outlier payment included in the total paid to the hospital was denied.

- **Services Not Covered -** Our review of billing records detected one instance when a hospital billed for a private room. Although private rooms are not generally covered by the Medicare program, the billing in this instance did not affect the hospital's payment since reimbursement was based upon the appropriate diagnosis-related group (DRG).

Recommendation

We recommend that Empire recover the improper payments of $14,827.28 related to the four sample claims for which OIG auditors identified errors.

REVIEW OF CLAIMS PROCESSED BY CARRIER

Medical review by Empire's carrier personnel and detailed testing by OIG auditors of 1,395 sampled claims identified 134[1] claims which did not comply with Medicare laws and regulations. These 134 claims resulted in improper payments totaling $6,817.81 as detailed below:

Error Category	2nd Qtr		3rd Qtr		Totals	
	# Error Lines	Error Amt.	# Error Lines	Error Amt.	# Error Lines	Error Amt.
No Documentation	4	$ 211.92	2	$ 20.31	6	$ 232.23
Insufficient Documentation	3	165.30	2	23.74	5	189.04
Services Incorrectly Coded	61	2,555.81	44	2,503.29	105	5,059.10
Services Provided by Someone Other than Billing	1	48.75	1	9.94	2	58.69
Services Billed Were Not Rendered	2	37.62	5	229.93	7	267.55
Duplicate Payment	4	82.81	3	253.48	7	336.29
Unbundling	1	67.34	5	560.82	6	628.16
Other Errors	1	18.32	1	28.43	2	46.75
Totals	77	$3,187.87	63	$3,629.94	140	$6,817.81

Claims Reviewed by Empire's Medical Review Staff – The majority of claims found to be in error were detected through reviews of the supporting medical records by Empire's medical review staff. Specifically, 135 of the total 140 error lines, or $6,270.78 of the $6,817.81 found to be in error, were denied based upon medical review determinations.

[1] 6 of the 134 claims had multiple error lines. In total, 140 lines on the 134 claims were found to be in error.

As noted in the table above, most of these improper payments involved instances when the provider used an incorrect code to bill for the services provided. The vast majority of these errors pertain to billings for evaluation and management codes for services such as office visits, hospital visits and consultations. A typical example of these errors is described in the example below:

- **Services Incorrectly Coded** - A physician was paid $392.06 for six days of subsequent hospital care for the evaluation and management of a patient. The procedure billed requires at least two of three key components: a detailed interval history, a detailed examination and medical decision making of high complexity. The medical reviewer determined that, for four of the days, the medical records only supported an expanded problem focused history, problem focused examination and medical decision making of moderate complexity. For the remaining two days, the medical records only supported a problem focused examination and medical decision making of straightforward or low complexity. As a result, Empire's medical review staff concluded that the provider had been overpaid a total of $146.06.

Examples of other errors identified by Empire's medical review staff are as follows:

- **Duplicate Payment** - A physician was paid $48.38 for initial hospital care for the evaluation and management of a patient. The provider acknowledged in writing that a billing error had occurred and that two physicians were paid for a single evaluation and management service. The medical reviewer also confirmed that the same documents supported the services billed by both providers on that date. As a result, two payments were issued for the same service on the same date. Therefore, one provider's claim for reimbursement of $48.38 was denied.

- **Unbundling** - A physician was paid $67.34 for an office visit that took place within the 90-day global surgery period. Although the visit was billed as unrelated to the earlier surgery, the medical reviewer concluded that the documentation clearly described a clinical evaluation related to the earlier surgery by the same provider. As a result, the provider's claim for reimbursement of $67.34 was denied.

Recommendations

We recommend that Empire recover and/or refund the improper payments totaling $6,270.78 noted by their medical review staff. In addition, to reduce the incidence of the types of errors identified through the CFO audit, we also recommend the Empire reinforce the requirements to bill services in accordance with Medicare policies such as the global surgery provision through its provider bulletins and other provider education efforts.

Additional testing by OIG Auditors – Detailed testing of carrier claims by OIG auditors identified four claims totaling $547.03 which should be denied, as illustrated by the examples below.

- **Duplicate Payment** - A physician billed an office visit for the evaluation and management of a patient and was paid $108.34. Based upon our review of the medical records and subsequent conversations with the physician's office, it was determined that this provider was paid on another claim for an office visit on this same date. The provider confirmed in writing that only one visit was provided, but that two visits had been billed in error. Therefore, the provider's $108.34 claim for reimbursement was denied.

- **Multiple Errors: Unbundling/Duplicate Payment** - A portable x-ray company was paid $79.98 for the professional and technical components of a chest x-ray provided to a resident of a SNF and for the set-up and transportation of the x-ray equipment to the SNF. Under the consolidated billing provisions for SNFs, the technical component of the chest x-ray, as well as the set-up and transportation of the equipment are included in the SNF's payment and are not separately billable to Medicare. Rather, the portable x-ray company should have sought reimbursement for these services directly from the SNF. In addition, although the professional component of the x-ray is not included in the payment to the SNF, the provider confirmed in writing that this service had mistakenly been billed twice. As a result, the provider's $79.98 claim for reimbursement was denied.

Recommendations

We recommend that Empire recover the improper payments of $547.03 identified by OIG auditors. We note that a Common Working File edit to prevent the types of consolidated billing errors identified through this audit is under development by CMS. In the meantime, we recommend that Empire remind its Part B providers, through provider bulletins and other educational efforts of the SNF consolidated billing requirements.

OTHER MATTERS

Our review of medical records identified 83 claims for which the performing provider listed on the claim was not the provider who actually rendered the service. Empire's medical review staff confirmed that someone other than the billing provider had rendered the service on two of these claims and accordingly, denied reimbursement.

For most of the remaining instances, we were able to identify a relationship (e.g., member of the same physician group or a common address) between the performing provider per the claim and the provider who had actually rendered the service as documented in the medical records. For nine of the claims, however, no such relationship appeared to exist. We note that such billing discrepancies could result in the claims' bypassing certain prepayment edits and could also distort the utilization statistics for individual providers. Additional details about these claims will, therefore, be provided to Empire under separate cover for further action.

CONCLUSION

As noted above, 163 of the 1,661 claims reviewed did not comply with Medicare laws and regulations. The improper payments for these claims amounted to $82,627.75, or 6.2% of the total payments of $1,330,919.24 in the sample. Most of the improper payments were detected through review of the supporting medical records and related to instances when an incorrect code had been used to bill for the services provided. The remaining payment errors related primarily to services which were provided in inappropriate inpatient settings or to services which were not rendered, not properly documented or not billed in accordance with Medicare guidelines.

RECOMMENDATIONS

We recommend that Empire:

- recover and/or refund the improper payments totaling $82,627.75 for the sample claims, and

- reinforce certain requirements through provider bulletins and other provider education opportunities to assure compliance with Medicare guidelines. Specifically, the review noted the need for improvement by providers in:

  - assuring that the medical records support the services claimed;
  - establishing the medical necessity of services rendered;
  - documenting and coding Medicare claims, particularly with respect to evaluation and management services;
  - complying with Medicare bundling requirements such as the global surgery and SNF consolidated billing provisions, and
  - monitoring their billings and receipts to assure timely detection of improper billings and payments (e.g., duplicate billings and improper outlier payments discussed above).

Empire Medicare Service's Comments

Empire, in its response dated June 14, 2002, concurred with the recommendations and noted that corrective actions have been initiated with respect to the reported findings. The full text of Empire's response is attached as an Appendix to this report.

Office of Audit Services' Response

We are pleased to note that Empire has initiated the recovery of overpayments and refund of underpayments and is planning to issue reminders and to undertake educational efforts with its providers to address the recommendations.

APPENDIX

CMS

CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

Part A Intermediary
Part B Carrier

June 14, 2002

Mr. Timothy J. Horgan
Regional Inspector General for Audit Services
DHHS Office of the Inspector General
26 Federal Plaza, Room 3900A
New York, New York 10278

Ref.: Common Identification Number A-02-01-01026

Dear Mr. Horgan:

This is in response to the draft OIG report "Review of FY 2001 Medicare Error Rate at Empire Medicare Services," pertaining to the sampled claims phase of the FY 2001 CFO Audit.

We concur with the findings as presented in the report.

It should be noted that recovery of overpayments and /or refunds was undertaken shortly after receiving the listing from the auditors.

We agree with the recommendations to issue reminders, via bulletins, to our Part A and Part B providers of the need to:

- properly document the medical records (intermediary)
- evaluate the necessity of services in inpatient hospital settings (intermediary)
- bill services in accordance with Medicare policies (carrier)
- adhere to the SNF consolidated billing requirements (carrier)

These bulletins will also be posted to our website. Additionally, the importance of these recommendations will be reinforced through our provider education and training activities.

Thank you for the opportunity to comment. If you have any questions, please call me at 315-442-4650.

Sincerely,

Lloyd S. Kasow
Medicare Coordination

CC: William E. Foley