October 28, 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of High-Dollar Payments for Virginia and West Virginia Outpatient Claims Processed by National Government Services for Calendar Years 2003–2005 (A-03-07-00015)

Attached is an advance copy of our final report on high-dollar payments for Virginia and West Virginia outpatient claims processed by National Government Services (NGS) for calendar years 2003–2005. We will issue this report to NGS within 5 business days. This audit was part of a nationwide review of payments for outpatient services of $50,000 or more (high-dollar payments).

Medicare guidance requires providers to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of service as the number of times that a service or procedure was performed.

Our objective was to determine whether the high-dollar Medicare payments that NGS made to providers for outpatient services were appropriate.

All 46 high-dollar payments that NGS made to providers were inappropriate. The 46 payments included overpayments totaling $3,510,611. Providers had not refunded $2,329,675 in overpayments for 35 claims at the time of our audit. Providers received these overpayments by billing for excessive units of service or by billing for the wrong service or procedure.

We recommend that NGS recover the estimated $2,329,675, and any additional amounts, for the 35 identified overpayments and use the results of this audit in its provider education activities.

In written comments on our draft report, NGS stated that it had recouped $2,331,586 for the 35 identified overpayments, $1,911 more than originally estimated, and that it was using its data analysis reports to identify similar billing errors.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Stephen Virbitsky, Regional Inspector General for Audit Services, Region III, at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov. Please refer to report number A-03-07-00015.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

October 29, 2009

Report Number: A-03-07-00015

Ms. Sandy Miller
President
National Government Services
8115 Knue Road
Indianapolis, Indiana 46250

Dear Ms. Miller:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Virginia and West Virginia Outpatient Claims Processed by National Government Services for Calendar Years 2003-2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

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 contact me at (215) 861-4470 or through email at Stephen.Virbitsky@oig.hhs.gov or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through email at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-07-00015 in all correspondence.

Sincerely,

/Stephen Virbitsky/
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, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR VIRGINIA AND WEST VIRGINIA OUTPATIENT CLAIMS PROCESSED BY NATIONAL GOVERNMENT SERVICES FOR CALENDAR YEARS 2003–2005

Daniel R. Levinson
Inspector General

October 2009
A-03-07-00015

Office of Inspector General

http://oig.hhs.gov

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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 age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments (providers). The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process payments for claims. The Common Working File can detect certain improper payments during prepayment validation.

Medicare guidance requires providers to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of service as the number of times that a service or procedure was performed.

National Government Services (NGS), formerly United Government Services, was the Medicare fiscal intermediary for Virginia and West Virginia during calendar years (CY) 2003–2005. NGS processed more than 12 million outpatient claims for Virginia and West Virginia, 46 of which resulted in payments of $50,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether the high-dollar Medicare payments that NGS made to providers for outpatient services were appropriate.

SUMMARY OF FINDINGS

All 46 high-dollar payments that NGS made to providers were inappropriate. The 46 payments included overpayments totaling $3,510,611. Providers refunded $554,164 of this amount prior to our audit and $626,772 as a result of our audit. Providers had not refunded $2,329,675 in overpayments for 35 claims at the time of our audit.

Providers received these overpayments by billing for excessive units of service or by billing for the wrong service or procedure. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2003–2005 to detect and prevent the overpayments.

RECOMMENDATIONS

We recommend that NGS:

- recover the estimated $2,329,675, and any additional amounts, for the 35 identified overpayments and

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

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, NGS stated that it had recouped $2,331,586 for the 35 identified overpayments, $1,911 more than originally estimated, and that it was using its data analysis reports to identify similar billing errors.

NGS's comments are included in their entirety as Appendix B.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments (providers). The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

To process providers' claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments during prepayment validation.

In calendar years (CY) 2003–2005, fiscal intermediaries processed and paid more than 409 million outpatient claims, 1,243 of which resulted in payments of $50,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

Claims for Outpatient Services

Providers generate the claims for outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of service as the number of times that the service or procedure was performed.

National Government Services

National Government Services (NGS), formerly United Government Services, was the Medicare fiscal intermediary for Virginia and West Virginia during CYs 2003–2005.[1] NGS processed more than 12 million outpatient claims for Virginia and West Virginia, 46 of which resulted in high-dollar payments.

[1]NGS was formed when AdminaStar Federal, Anthem Health Plans of New Hampshire, Associated Hospital Service, Empire Medicare Services, and United Government Services merged on January 1, 2007. NGS has offices in Indianapolis, Indiana; Louisville, Kentucky; and Charleston, West Virginia.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the high-dollar Medicare payments that NGS made to providers for outpatient services were appropriate.

Scope

We reviewed the 46 high-dollar payments for outpatient claims that NGS processed for Virginia and West Virginia providers during CYs 2003–2005. We limited our review of NGS's internal controls to those applicable to the 46 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.

We conducted our audit work from November 2008 through April 2009. Our audit included contacting NGS and the 17 providers that received the 46 high-dollar Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify outpatient claims with high-dollar payments;
- reviewed available Common Working File data for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims and whether payments remained outstanding at the time of our audit;
- contacted the providers that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect; and
- coordinated the calculation of overpayments and discussed the results of our review with NGS.

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

All 46 high-dollar payments that NGS made to providers were inappropriate. The 46 payments included overpayments totaling $3,510,611. Providers refunded $554,164 of this amount prior to our audit and $626,772 as a result of our audit. Providers had not refunded $2,329,675 in overpayments for 35 claims at the time of our audit.

Providers received these overpayments by billing for excessive units of service or by billing for the wrong service or procedure. NGS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2003–2005 to detect and prevent the overpayments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires providers to report claims for outpatient services using Healthcare Common Procedure Coding System codes. CMS's "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 4, section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of this manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" requires the fiscal intermediary to maintain adequate internal controls over Medicare automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

NGS made 35 overpayments totaling $2,329,675, which providers had not refunded at the time of our audit.

- For 32 of the 35 overpayments, providers billed NGS for excessive units of service. As a result, NGS paid providers $2,280,976 when it should have paid $209,434, resulting in overpayments totaling $2,071,542.

- For the three remaining overpayments, providers billed NGS for the wrong service or procedure. As a result, NGS paid the providers $264,121 when it should have paid $5,988, resulting in overpayments totaling $258,133.

Appendix A details each provider overpayment not refunded at the time of our audit.

CAUSES OF OVERPAYMENTS

The providers attributed the incorrect payments to clerical errors made by their billing staffs and to problems with incorrect data in their billing systems. In addition, during CYs 2003–2005, NGS did not have sufficient prepayment or postpayment controls to identify overpayments at the

payment level, and the Common Working File prepayment process lacked edits to detect and prevent excessive payments. In effect, CMS relied on providers to notify the intermediaries of excessive payments and on beneficiaries to review their "Medicare Summary Notice" and disclose any overpayments.[2]

FISCAL INTERMEDIARY PREPAYMENT EDITS

On January 3, 2006, after our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends high-dollar outpatient payments and requires intermediaries to determine the legitimacy of the payments.

NGS stated that it had an edit in place during our audit period that suspended for prepayment review all claims with payment amounts greater than $150,000. Beginning January 3, 2006, NGS reduced the edit limit to payment amounts greater than $50,000. NGS reviewed claims that exceeded the limit and verified the units and amount billed with the providers. If the providers verified that the units and amount billed were correct, NGS processed the claims. If the providers did not verify the units and amount billed, NGS returned the claims to the providers for correction.

RECOMMENDATIONS

We recommend that NGS:

- recover the estimated $2,329,675, and any additional amounts, for the 35 identified overpayments and

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

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, NGS stated that it had recouped $2,331,586 for the 35 identified overpayments, $1,911 more than originally estimated, and that it was using its data analysis reports to identify similar billing errors.

NGS's comments are included in their entirety as Appendix B.

[2]The fiscal intermediary sends a "Medicare Summary Notice" to the beneficiary after the hospital files a claim for outpatient services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIXES

APPENDIX A: OVERPAYMENTS NOT REFUNDED

Provider Billed for Excessive Units of Service

Claim No.	Service Billed	Quantity Billed	Quantity Performed	Paid Amount	Corrected Amount	Overpayment
15 - 194	Laminectomy	6	1	$61,980	$10,418	$51,562
15 - 197	Oxaliplatin	624	72	55,517	8,424	47,093
15 - 211	Heart catheterization	481	1	117,035	2,702	114,333
15 - 223	Laminectomy	4	1	50,944	24,045	26,899
15 - 224	Paclitaxel	730	26	56,386	1,880	54,506
15 - 234	Paclitaxel	630	22	52,146	4,794	47,352
15 - 241	Pactitarel	765	30	60,983	5,971	55,012
15 - 237	Oxaliplatin	712	72	57,492	5,241	52,251
15 - 238	Oxaliplatin	728	74	58,786	5,349	53,437
15 - 243	Factor VIII	132,000	12,400	135,592	13,651	121,941
15 - 208	Oxaliplatin	400	40	50,218	2,891	47,327
15 - 209	Oxaliplatin	600	60	50,569	5,528	45,041
15 - 213	Oxaliplatin	600	60	53,540	8,126	45,414
15 - 214	Oxaliplatin	600	60	52,894	7,578	45,316
15 - 215	Oxaliplatin	600	60	53,547	1,363	52,184
15 - 216	Oxaliplatin	1,200	120	99,154	8,775	90,379
15 - 217	Oxaliplatin	800	80	66,152	5,886	60,266
15 - 218	Oxaliplatin	800	80	66,118	5,852	60,266
15 - 225	Cytomegalovirus	200	1	131,433	771	130,662
15 - 226	Oxaliplatin	800	80	66,521	6,216	60,305
15 - 227	Oxaliplatin	800	80	65,878	5,570	60,308
15 - 228	Oxaliplatin	800	80	67,054	6,516	60,538
15 - 229	Oxaliplatin	800	80	67,430	6,815	60,615
15 - 230	Oxaliplatin	800	80	66,654	6,815	59,839
15 - 231	Oxaliplatin	800	80	68,103	7,487	60,616
15 - 232	Oxaliplatin	900	90	72,037	6,296	65,741
15 - 233	Oxaliplatin	900	90	72,231	6,433	65,798
15 - 242	Fluorodeoxyglucose	400	2	129,399	877	128,522
15 - 244	Oxaliplatin	900	90	74,368	7,219	67,149
15 - 245	Oxaliplatin	800	80	66,727	6,282	60,445
15 - 246	Oxaliplatin	800	80	66,123	5,922	60,201
15 - 247	Oxaliplatin	800	80	67,965	7,741	60,224
32	**Subtotal**			**$2,280,976**	**$209,434**	**$2,071,542**

Provider Billed for Wrong Service or Procedure

Claim No.	Service Billed	Procedure Billed	Procedure Performed	Paid Amount	Corrected Amount	Overpayment
15 - 212	Pegfilgrastim / Octreotide	J2505	J2353	$77,021	$1,784	$75,237
15 - 219	Fluorodeoxyglucose / Darbepoetin alfa	C1775	Q0137	128,271	1,363	126,908
15 - 207	Alemtuzumab / Capecitabine	J9010	J8520	58,829	2,841	55,988
3	**Subtotal**			**$264,121**	**$5,988**	**$258,133**
35	**Total**			**$2,545,097**	**$215,422**	**$2,329,675**

APPENDIX B: NATIONAL GOVERNMENT SERVICES COMMENTS

National Government Services

PO Box 4846
Syracuse, New York 13221-4846
www.NGSMedicare.com

A CMS Contracted Agent

Medicare

September 2, 2009

Mr. Bernard Siegel
Office of Audit Services, Region III
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Re: NGS Response to OIG audit A-03-07-00015 "Review of High-Dollar Payments for Virginia and West Virginia Outpatient Claims Processed by National Government Services for Calendar Years 2003 – 2005."

Dear Mr. Siegel:

This letter is in response to draft report A-03-07-00015, entitled " Review of High-Dollar Payments for Virginia and West Virginia Outpatient Claims Processed by National Government Services for Calendar Years 2003 – 2005."

Medicare guidance requires providers to submit accurate claims for Outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of services as the number of times that a service or procedure was performed. The objective of this audit was to determine whether the high-dollar Medicare payments that NGS made to providers for Outpatient services were appropriate.

During this period, NGS processed more than 12 million outpatient claims for Virginia and West Virginia, 46 of which resulted in payments of $50,000 or more (high-dollar payments). According to your findings, all 46 high-dollar payments that NGS made were inappropriate. These 46 payments resulted in overpayments totaling $3, 510,611. At the time of this audit, providers refunded a portion of the overpayment dollars leaving $2,329,675 in overpayments to be recouped (35 claims).

The overpayments occurred due to providers billing for excessive units of service or billing for the wrong service or procedure. NGS made these overpayments because neither the Fiscal Intermediary Shared System nor the Common Working File had sufficient edits in place during CYs 2003 – 2005 to detect and prevent the overpayments.

Your recommendation is that NGS recovers $2,329,675 for the identified overpayments and use the results of this audit in its provider education activities. In response to your recommendations NGS has done the following:

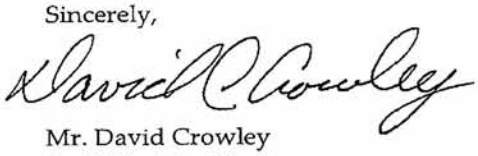
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

- As of 8/27/09, NGS has recouped a total of $2,331,586 from providers which the 35 overpayments occurred. The overpayment amount recouped is slightly different than the amount quoted initially to the OIG auditor ($1,911 to be exact). However, this is due to the fact that the original adjustment amounts provided were estimates only based on claims processed through the test system and not actual production. Therefore, once the adjustments were processed by the provider the payment amounts varied slightly on most of the adjustments.

- NGS has also discussed this particular audit with our Provider Outreach and Clinical Education department. Through data analysis reports, NGS is currently addressing these types of billing issues. Our POCE and Medical Review departments currently review data analysis reports which identify provider aberrancies. After the data is analyzed, POCE notifies the providers, in writing, and request that they either explain or correct the discrepancy. We believe through this method of education, we are identifying and addressing this area of concern.

You may submit any additional questions and/or concerns to the NGS Medicare mailbox; ngs.medicare@ anthem.com.

Sincerely,



Mr. David Crowley
Staff Vice President

Claims Management

cc: Pam Glenn, Part A/RHHI Claims Director,
Sandra Logan, Claims Manager