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

FEB 12 2009

Report Number: A-03-07-00016

Mr. E. James Bylotas
Director, Quality & Performance Management
Highmark Medicare Services
1800 Center Street
Camp Hill, Pennsylvania 17089

Dear Mr. Bylotas:

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 Pennsylvania Medicare Part B Claims Processed by Highmark Medicare Services for the Period January 1, 2003, Through December 31, 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.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through e-mail at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-07-00016 in all correspondence.

Sincerely,

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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 PENNSYLVANIA MEDICARE PART B CLAIMS PROCESSED BY HIGHMARK MEDICARE SERVICES FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

February 2009
A-03-07-00016

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the 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 carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers). CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed.

Carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File to process Part B claims. These systems can detect certain improper payments during prepayment validation.

Highmark Medicare Services (Highmark), a subsidiary of Highmark, Incorporated, was the Medicare Part B carrier for Pennsylvania. During calendar years (CY) 2003–05, Highmark processed more than 101 million claims as the Part B carrier, 801 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Highmark's high-dollar payments as the Medicare Part B carrier for Pennsylvania were appropriate.

SUMMARY OF FINDING

Two hundred sixty-two of 311 sampled high-dollar payments Highmark made as the carrier for Pennsylvania were appropriate, and Highmark was reviewing 1 additional payment at the time of our audit. However, Highmark overpaid $482,295 for 48 payments to 16 providers. Seven providers refunded $340,823 for 27 of the overpayments prior to our audit. Many of these overpayments were related to manually processed claims for hemophilia drugs. Seven providers refunded $100,896 in overpayments for 16 of the overpayments as a result of our audit. (One of these seven providers also refunded overpayments prior to the audit.) Three providers had not refunded $40,576 in overpayments for five claims at the time of our audit.

Highmark made the overpayments because 13 providers billed Highmark for the incorrect number of units of service and one of these providers billed Highmark for the wrong services for the administration of drugs. Also, Highmark used the incorrect quantity when it manually calculated the payment for certain drugs on 22 claims and used incorrect rates to pay for drugs on 2 claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–05 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that Highmark:

- recover the $40,576 in overpayments and

- consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY 2005.

HIGHMARK MEDICARE SERVICES COMMENTS

In comments on our draft report (Appendix B), Highmark stated that it concurred with our first recommendation and initiated activity to recover the $40,576 in identified overpayments but that it did not believe it necessary to implement a special review of high dollar claims at this time.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people 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 Part B Carriers

Prior to October 1, 2005, section 1842(a) of the Act authorized CMS to contract with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers).[1] Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process providers' claims, carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. During calendar years (CY) 2003–05, providers nationwide submitted approximately 2.3 billion claims to carriers. Of these, 29,022 claims resulted in payments of $10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

Highmark Medicare Services

Highmark Medicare Services (Highmark), a subsidiary of Highmark Incorporated, was the Medicare Part B carrier for Pennsylvania.[2] Highmark used the Medicare Multi-Carrier Claims System to process claims. During CYs 2003–05, Highmark processed more than 101 million Part B claims for Pennsylvania, 801 of which resulted in high-dollar payments.

"Medically Unlikely Edits"

In January 2007, after our audit period, CMS required carriers to implement units-of-service edits referred to as "medically unlikely edits." These edits are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the "Medicare Program Integrity Manual," Pub. No. 100-08, Transmittal 178, Change Request 5402, a "medically unlikely edit" tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a specified number of units of service. Carriers must deny the entire claim line when the units of service billed exceed the specified number.

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[1]The Medicare Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace carriers and fiscal intermediaries by October 2011.

[2]Highmark Medicare Services has offices in Camp Hill, Pittsburgh, Williamsport, and Fort Washington, Pennsylvania, and Timonium, Maryland.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Highmark's high-dollar payments as the Medicare Part B carrier for Pennsylvania were appropriate.

Scope

We reviewed the claim histories for the 801 high-dollar payments totaling $18,876,409 that Highmark processed during CYs 2003–05 and selected 311 payments totaling $6,625,262 for more detailed review.[3]

We limited our review of Highmark's internal controls to those applicable to the 801 claims 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 from August through December 2007 and May through October 2008.

Methodology

To accomplish our objectives, we:

- reviewed applicable Medicare laws and regulations,
- used CMS's National Claims History file to identify Medicare Part B 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 or whether the payments remained outstanding at the time of our audit,
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments, and
- selected a judgmental sample of 311 of 801 high-dollar payments for detailed review.

Our sample included 23 payments for which Highmark had made an adjustment to a previous overpayment. From the remaining 778 high-dollar payments we selected a judgmental sample of 288 payments that included payments for all 138 payments submitted by 31 providers and a

[3]When the Common Working File history was not available due to the age of the claim, we obtained a claim history from Highmark that contained comparable information.

representative sample of 150 payments from the remaining 640 payments from 7 providers who had each submitted from 40 to 309 claims.

- For the 23 adjusted payments totaling $883,489, we contacted Highmark to determine whether providers refunded overpayments that were identified in the Common Working File.

- For the 288 payments totaling $5,781,992, we contacted the providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly.

- We coordinated our claim review, including the calculation of any overpayments, with Highmark.

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 finding and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

Two hundred sixty-two of 311 high-dollar payments Highmark made as the carrier for Pennsylvania were appropriate, and Highmark was reviewing 1 additional payment at the time of our audit.[4] However, Highmark overpaid $482,295 for 48 payments to 16 providers. Seven providers refunded $340,823 for 27 of the overpayments prior to our audit. Many of these overpayments were related to manually processed claims for hemophilia drugs. Seven providers refunded $100,896 in overpayments for 16 of the overpayments as a result of our audit.[5] Three providers had not refunded $40,576 in overpayments for five claims at the time of our audit.

Highmark made the overpayments because 13 providers billed Highmark for the incorrect number of units of service and one of these providers billed Highmark for the wrong services for the administration of drugs. Also, Highmark used the incorrect quantity when it manually calculated the payment for certain drugs on 22 claims and used incorrect rates to pay for drugs on 2 claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–05 to detect and prevent payments for these types of erroneous claims.

MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Pub. No. 14, part 2, § 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and instructions. Section 5261.3

[4]Highmark and the provider were reviewing one high-dollar payment but had not yet adjudicated the final payment amount. Because the claim had been under review for an extended period of time and the final payment amount was not determined, we did not include the payment in our review.

[5]One of these providers also refunded overpayments prior to the audit.

of the manual requires carriers to effectively and continually analyze "data that identifies aberrancies, emerging trends and areas of potential abuse, overutilization or inappropriate care, and . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Highmark overpaid providers $482,295 for 48 payments, including 24 payments for incorrect units or services claimed by the providers and 24 payments calculated by Highmark using incorrect quantities or payment rates. (See Appendix A for details.)

Excessive Units or Incorrect Services Billed

For 19 of the 48 overpayments, totaling $228,791, 13 providers incorrectly billed Highmark for the incorrect number of units of service. For 17 of these overpayments, providers submitted claims for quantities of drugs or services that were greater than provided. For two of the overpayments, the providers' medical billing company submitted claims for units of intensity modulated radiation therapy that were significantly greater than the number actually performed. As a result, Highmark paid the providers $273,884 instead of $45,093. Providers refunded $92,217 in overpayments to Highmark prior to our audit and $100,678 in overpayments as a result of our audit. Providers had not refunded $35,896 in overpayments for three claims at the time of our audit.

For 5 of the 48 overpayments, totaling $218, 1 of the 13 providers incorrectly billed Highmark for the wrong services for the administration of drugs. As a result Highmark paid the provider $291 when it should have paid $73 resulting in overpayments totaling $218. The provider refunded $218 in overpayments as a result of our audit.

The providers attributed the incorrectly billed units and services to clerical errors made by its billing staff.

Incorrect Quantities or Payment Rates

For 22 of the 48 overpayments, totaling $234,132, Highmark used incorrect quantities to pay for three drugs: octreotide, Factor VIIa and Factor VIII. For two of these drugs, which represented almost all of the error, Highmark used the incorrect quantity when it manually calculated the payments. Highmark's automated processing system could not process claims with the large numeric quantities required for these drugs. Highmark incorrectly calculated the quantities when it manually divided the single claims into multiple claims. As a result, Highmark paid the providers $795,579 instead of $561,447, resulting in overpayments totaling $234,132. Providers refunded $229,452 in overpayments prior our audit. Providers had not refunded $4,680 in overpayments for two claims at the time of our audit.

For 2 of the 48 overpayments, totaling $19,154, Highmark used incorrect rates to pay for two different hemophilia drugs—Factors VIII, and IX. Highmark calculated the payment for these claims manually because the carrier automated processing system was unable to process claims

with the large numeric quantities required for these drugs. During the manual processing, the incorrect payment rates were used for the drugs provided. As a result, Highmark paid the providers $57,504 instead of $38,350, resulting in overpayments totaling $19,154. Providers refunded the full overpayment amount to Highmark prior to our audit.

Highmark attributed the overpayments to clerical errors made during the manual payment process.

STATUS OF OVERPAYMENTS

For the 48 overpayments totaling $482,295 made by Highmark to 16 providers, 7 providers refunded $340,823 for 27 of the overpayments prior to our audit. Most of those overpayments were related to manually processing hemophilia drugs. Seven providers refunded $100,896 in overpayments for 16 of the overpayments, as a result of our audit. (One of these seven providers also refunded overpayments prior to the audit.) Three providers had not refunded $40,576 in overpayments for five claims at the time of our audit.

INSUFFICIENT PREPAYMENT CONTROLS

During CYs 2003–05, Highmark, the Medicare Multi-Carrier Claims System, and the CMS Common Working File did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service or claims processed using the wrong payment rate. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[6]

RECOMMENDATIONS

We recommend that Highmark:

- recover the $40,576 in overpayments and

- consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY 2005.

HIGHMARK MEDICARE SERVICES COMMENTS

In comments on our draft report, Highmark stated that it concurred with our first recommendation and initiated activity to recover the $40,576 in identified overpayments but that it did not believe it necessary to implement a special review of high dollar claims at this time. Highmark's comments are included as Appendix B.

[6]The carrier sends a "Medicare Summary Notice" to the beneficiary for each claim submitted by the provider for Part B services on a quarterly basis. The notice explains the services billed, the approved amount, the Medicare payment, and the amount the beneficiary may be billed.

APPENDIXES

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

PROVIDER SUBMITTED CLAIM TO HIGHMARK WITH THE INCORRECT QUANTITY

Provider		Units		Amount			Amount Refunded		
Claim No.	Service Billed	Billed	Performed	Paid	Corrected	Overpayment	Prior to Audit	During Audit	Not Refunded
A 16-758	Radiation Therapy	62	1	$31,244	$504	$30,740	$30,740		
B 16-676	Radiation Therapy	50	5	25,197	2,520	22,677	22,677		
C 16-579	Docetaxel	60	Unknown	15,761		15,761			15,761
C 16-587	Pamidronate Disodium	60	2	11,418	381	11,037			11,037
C 16-775	Chemotherapy	80	1	9,213	115	9,098			9,098
D 16-311	Pegfligrastim	6	1	13,452	2,242	11,210		11,210	
D 16-510	Octreotide	301	30	17,118	1,706	15,412		15,412	
E 16-437	Oxaliplatin	16	2	24,180	3,022	21,158		21,158	
F 16-601	Doxorubicin Hydrochloride	60	6	18,887	1,889	16,998		16,998	
G 16-716	Fulvestrant	250	10	15,672	627	15,045		15,045	
H 16-487	Medical Consultation	92	1	13,840	151	13,689	13,689		
I 16-362	Pentostatin	8	1	12,330	1,541	10,789		10,789	
I 16-407	Office Visit (not reimbursable)	1	0	15	0	15		15	
I 16-423	Office Visit (not reimbursable)	1	0	16	0	16		16	
I 16-718	Oxaliplatin	650	300	4,433	2,046	2,387		2,387	
J 16-582	Evaluation & Management	338	0	12,900	0	12,900	12,900		
K 16-714	Darbepoetin Alfa	800	80	13,568	1,357	12,211	12,211		
L 16-715	Leuprolide	30	8	10,410	2,776	7,634		7,634	
M 16-114	Factor VIII	24,038	24,024	24,230	24,216	14		14	
19				**$273,884**	**$45,093**	**$228,791**	**$92,217**	**$100,678**	**$35,896**

PROVIDER SUBMITTED CLAIM TO HIGHMARK WITH THE INCORRECT SERVICE CODE

Provider		Procedure Code		Amount			Amount Refunded		
Claim No.	Service Billed	Billed	Performed*	Paid	Corrected	Overpayment	Prior to Audit	During Audit	Not Refunded
I 16-413	Infusion Therapy/Evaluation & Management	90781 / 99211	90780 / SNR	$47	$16	$31		$31	
I 16-419	Infusion Therapy/Evaluation & Management	90781 / 99211	90780 / SNR	48	16	32		32	
I 16-430	Infusion Therapy/Evaluation & Management	90781 / 99211	90780 / SNR	48	16	32		32	
I 16-443	Infusion Therapy/Evaluation & Management	90781	90780	50	25	25		25	
I 16-502	Infusion Therapy/Evaluation & Management	G0347 / G0348	G0359 / G0360	98	0	98		98	
5				**$291**	**$73**	**$218**	**$0**	**$218**	**$0**

***SNR = Service Not Reimbursable.**

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

HIGHMARK PROCESSED THE CLAIM MANUALLY USING AN INCORRECT QUANTITY

Provider		Units		Amount			Amount Refunded		
Claim No.	Service Billed	Paid	Corrected	Paid	Corrected	Overpayment	Prior to Audit	During Audit	Not Refunded
M 16-221	Factor VIII	25,584	24,480	$21,531	$20,602	$929	$929		
M 16-397	Factor VIII	15,660	13,080	10,899	9,104	1,795	1,795		
M 16-398	Factor VIII	17,160	13,080	11,944	9,104	2,840	2,840		
N 16-150	Factor VIIa - Split Claim #1a	38.4	32.0	51,656	43,046	8,610	8,610		
N 16-151	Factor VIIa - Split Claim #1b	38.4	32.0	51,656	43,046	8,610	8,610		
N 16-171	Factor VIIa - Split Claim #1c	23.3	13.0	31,400	17,487	13,913	13,913		
N 16-172	Factor VIIa - Split Claim #1d	59.3	33.0	79,707	44,391	35,316	35,316		
N 16-173	Factor VIIa - Split Claim #1e	35.9	20.0	48,307	26,904	21,403	21,403		
N 16-178	Factor VIIa - Split Claim #2a	41.7	29.2	40,948	28,664	12,284	12,284		
N 16-180	Factor VIIa - Split Claim #2b	40.5	28.3	39,778	27,845	11,933	11,933		
N 16-181	Factor VIIa - Split Claim #2c	39.3	27.5	38,608	27,026	11,582	11,582		
N 16-182	Factor VIIa - Split Claim #2d	38.1	26.7	37,438	26,207	11,231	11,231		
N 16-183	Factor VIIa - Split Claim #2e	36.9	25.8	36,268	25,388	10,880	10,880		
N 16-184	Factor VIIa - Split Claim #2f	34.3	24.0	33,694	23,586	10,108	10,108		
N 16-179	Factor VIIa - Split Claim #3a	41.7	29.2	40,948	28,664	12,284	12,284		
N 16-185	Factor VIIa - Split Claim #3b	40.5	28.3	39,778	27,845	11,933	11,933		
N 16-186	Factor VIIa - Split Claim #3c	39.3	27.5	38,608	27,026	11,582	11,582		
N 16-187	Factor VIIa - Split Claim #3d	38.1	26.7	37,438	26,207	11,231	11,231		
N 16-188	Factor VIIa - Split Claim #3e	36.9	25.8	36,268	25,388	10,880	10,880		
N 16-189	Factor VIIa - Split Claim #3f	34.3	25.0	33,694	24,569	9,125	9,125		
O 16-725	Factor VIII	318,000	31,800	24,931	22,133	2,798			2,798
P 16-536	Octreotide	1,200	120	10,080	8,198	1,882			1,882
22				**$795,579**	**$562,430**	**$233,149**	**$228,469**	**$0**	**$4,680**

HIGHMARK PROCESSED THE CLAIM MANUALLY USING AN INCORRECT RATE

Provider		Rate		Amount			Amount Refunded		
Claim No.	Service Billed	Paid	Corrected	Paid	Corrected	Overpayment	Prior to Audit	During Audit	Not Refunded
N 16-124	Factor IX	1.870	0.884	$36,263	$17,142	$19,121	$19,121		
M 16-273	Factor VIII	1.054	1.052	21,241	21,208	33	33		
2				**$57,504**	**$38,350**	**$19,154**	**$19,154**	**$0**	**$0**
48				**1,127,258**	**645,946**	**481,312**	**339,840**	**100,896**	**40,576**

HIGHMARK.
MEDICARE SERVICES
ISO 9001:2000 CERTIFIED

Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

February 9, 2009

OIG Report Number: A-03-07-0016

Dear Mr. Virbitsky:

Attached is the Highmark Medicare Services' response to your request for comments on the draft report entitled, "Review of High-Dollar Payments for Pennsylvania Medicare Part B Claims Processed by Highmark Medicare Services for the Period January 1, 2003 through December 31, 2005."

Please do not hesitate to contact me at (717) 302-4410 if you have any questions.

Sincerely,

E. James Bylotas
Director, Quality and Performance Management

CC: Bernard Siegel

Highmark Medicare Services
Response to OIG Audit A-03-07-0016

I. Inappropriate High-Dollar Payments/ Status of Overpayments

"Highmark overpaid providers $482,295 for 48 payments, including 24 payments for incorrect units or services claimed by the providers and 24 payments calculated by Highmark using incorrect quantities or payment rates. For the 48 overpayments made by Highmark to 16 providers, 7 providers refunded $340,823 for 27 of the overpayments prior to our audit. Most of those overpayments were related to manually processing hemophilia drugs. Seven providers refunded $100,896 in overpayments for 16 of the overpayments, as a result of our audit. (One of these seven providers also refunded overpayments prior to the audit.) Three providers had not refunded $40,576 in overpayments for five claims at the time of our audit."

Recommendation

"We recommend Highmark recover the $40,576 in overpayments."

Highmark Medicare Services Response

We agree with the recommendation and have initiated activity to recover the $40,576 in overpayments.

Recommendation

"Consider identifying and recovering any additional overpayments made to providers for high-dollar Part B claims paid after CY2005."

Highmark Medicare Services Response

Highmark Medicare Services Informatics Team conducts proactive data analysis on an ongoing basis to determine unusual patterns and discover issues of risk for the Medicare program and uses this information to direct Medical Review resources. As part of this larger analytic effort, one specific approach (called Six-Sigma Analysis) that is used for Part B services is to monitor the number of services that are billed each month for each procedure code and highlight those which have an abnormal change in any given month based on the usual month-to-month variability that is seen in the code. Any large deviation in the number of services would trigger a review by our data analysts. While this is slightly different than monitoring for high-dollar claims, the relationship between services and dollars is clear. One advantage of this approach is that services are not subject to provisions such as deductible and coinsurance which can have an effect on the variation on any dollar based variable.

In fact, using this very analytic technique, Highmark Medicare Services has routinely identified unusual and high dollar claims for hemophilia drugs. However, since hemophilia drugs are already subject to a 100% pre-pay review, Medical Review resources are usually targeted for other issues that are in line with the MR strategy.

The OIG review of 311 claims (worth $6,625,626) found that at the time of their review there were $141,427 dollars that had not been appropriately accounted. This corresponds to a dollar based error rate of about 2% ($141,427 / $6,625,626 = 2.1%) for high dollar claims, while error rates for E&M services routinely are in the range of 6% - 8% or more (according to CERT data). Additionally, there are typically only a few hundred high-dollar claims per year while there are tens of millions of E&M services billed annually.

Given Highmark Medicare Services success at detecting the high dollar claim issues in the past (especially for hemophilia), the low error rate associated with these dollars vis-à-vis E&M services, and the recent advent of MUEs (as noted by the OIG) as well as CUEs (which were not available until recently), we do not believe it is necessary to implement a special review of high dollar claims at this time. However, Highmark Medicare Services will incorporate the OIG findings into its prioritization scale when issues related to hemophilia drugs are discovered in the future using current techniques.

II. Insufficient Prepayment Controls

During CYs 2003-05, Highmark, the Medicare Multi-Carrier Claims System, and the CMS Common Working File did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service or claims processed using the wrong payment rate. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.

Highmark Medicare Services Response
Highmark Medicare Services has implemented a Medically Unlikely Edit (MUE) to suspend potentially excessive Medicare Payments for prepayment review as required by CMS. We have also established our own "Clinically Unlikely Edits (CUE). In addition, we monitor the number of units billed using postpayment data analysis.