DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

AUG 24 2009

Report Number: A-07-08-04135

Mr. Jay Martinson
Executive Vice President, Chief Operating Officer
Noridian Administrative Services, LLC
900 42nd Street South
P.O. Box 6055
Fargo, North Dakota 58103-2146

Dear Mr. Martinson:

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 Medicare Part B Claims Processed by Noridian Administrative Services, LLC, 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 at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-08-04135 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
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE PART B CLAIMS PROCESSED BY NORIDIAN ADMINISTRATIVE SERVICES, LLC, FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

August 2009
A-07-08-04135

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.

During our audit period (calendar years (CY) 2003 through 2005), Noridian Administrative Services, LLC (Noridian), was the Medicare Part B carrier serving Medicare providers in eleven States. During this period, Noridian processed approximately 193.5 million Part B claims, 1,644 of which had payments of $10,000 or more. We considered these high-dollar claims to be at risk for overpayment.

OBJECTIVE

Our objective was to determine whether high-dollar Medicare claims that Noridian processed and paid to Part B providers were appropriate.

SUMMARY OF FINDING

Of the 1,644 high-dollar payments that Noridian made to providers, 1,578 were appropriate. However, Noridian overpaid providers $708,878 for the remaining 66 payments. Providers refunded 12 of the overpayments, totaling $139,028, prior to our fieldwork. However, 54 overpayments, totaling $569,850, remained outstanding as of the time of our fieldwork.

Noridian made the overpayments because the providers incorrectly claimed excessive units of service or used inappropriate procedure codes, or because Noridian applied incorrect payment rates for procedure codes. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003 through 2005 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that Noridian:

- recover the $569,850 in overpayments,

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

- identify and recover any additional overpayments made for high-dollar Part B claims paid after CY 2005.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Noridian partially concurred with our first recommendation and concurred with our second recommendation, but did not concur with our third recommendation. Noridian's comments are included in their entirety as the Appendix.

After reviewing Noridian's written comments, we maintain that our findings and recommendations are valid.

TABLE OF CONTENTS

Page

INTRODUCTION 1

BACKGROUND 1
Medicare Part B Carriers 1
Noridian Administrative Services, LLC 1
"Medically Unlikely" Edits 1

OBJECTIVE, SCOPE, AND METHODOLOGY 2
Objective 2
Scope 2
Methodology 2

FINDINGS AND RECOMMENDATIONS 3

MEDICARE REQUIREMENTS 3

INAPPROPRIATE HIGH-DOLLAR PAYMENTS 3

RECOMMENDATIONS 4

AUDITEE COMMENTS 4

OFFICE OF INSPECTOR GENERAL RESPONSE 5

APPENDIX

AUDITEE COMMENTS

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

Section 1842(a) of the Act authorizes 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 use 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 through 2005, providers nationwide submitted over 2.4 billion Medicare Part B 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.

Noridian Administrative Services, LLC

During our audit period (CYs 2003 through 2005), Noridian Administrative Services, LLC (Noridian), was the Medicare Part B carrier serving Medicare providers in eleven States. During this period, Noridian processed approximately 193.5 million Part B claims that had payments of approximately $16.3 billion. Of these claims, Noridian processed 1,644 Part B claims that had 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," Publication 100-08, Transmittal 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, Healthcare Common Procedure Code System 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.

[1]The Medicare Prescription Drug, Improvement, and 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 (MAC) replace carriers and fiscal intermediaries by October 2011.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare claims that Noridian processed and paid to Part B providers were appropriate.

Scope

We reviewed the 1,644 high-dollar claims, totaling $29,029,150, that Noridian processed during CYs 2003 through 2005.

We limited our review of Noridian's internal controls to those applicable to the 1,644 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 fieldwork from July 2007 through April 2009. Our fieldwork included contacting Noridian, located in Fargo, North Dakota, and the providers that received the payments for the high-dollar claims.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify Medicare Part B claims with high-dollar payments;
- reviewed available Common Working File claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;
- coordinated our claim review with Noridian, and provided Noridian with the details (as discussed below) of the 54 claims totaling $569,850 in overpayments;
- contacted providers to determine whether the high-dollar claims were billed correctly; and
- obtained documentation from the providers confirming all correct claims identified.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our

audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 1,644 high-dollar payments that Noridian made to providers, 1,578 were appropriate. However, Noridian overpaid providers $708,878 for the remaining 66 payments. Providers refunded 12 of the overpayments, totaling $139,028, prior to our fieldwork. However, 54 overpayments, totaling $569,850, remained outstanding as of the time of our fieldwork.

Noridian made the overpayments because the providers incorrectly claimed excessive units of service or used inappropriate procedure codes, or because Noridian applied incorrect payment rates for procedure codes. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003 through 2005 to detect and prevent payments for these types of erroneous claims.

MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Publication 14, part II, section 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and instructions. Section 5261.3 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 . . . areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

For several of the overpayments, providers incorrectly billed Noridian for excessive units of service. As examples:

- One provider billed 80 units of service when it should have billed 8 units, resulting in an overpayment of $23,381.

- One provider billed 60 units of service when it should have billed 6 units, resulting in an overpayment of $19,696.

- One provider billed 501 units of service when it should have billed 50 units, resulting in an overpayment of $19,239.

- One provider billed 60 units of service when it should have billed 6 units, resulting in an overpayment of $18,458.

Additional overpayments occurred when providers used inappropriate procedure codes, and when Noridian applied incorrect payment rates for procedure codes. As examples:

- One provider billed 11 units of procedure code J9268 when it should have billed 11 units of procedure code J9265, resulting in an overpayment of $13,253.

- One provider billed 1 unit of procedure code G0345 and 12 units of procedure code J9266 instead of 1 unit of procedure code G0349 and 13 units of procedure code J9265, resulting in an overpayment of $12,237.

- Noridian reimbursed one provider at the billed amount, instead of reimbursing at the allowable amount for procedure code A0435, resulting in an overpayment of $17,638.

- Noridian reimbursed one other provider at the billed amount, instead of reimbursing at the allowable amount for procedure code A0435, resulting in an overpayment of $15,659.

Providers attributed the submission of claims with incorrect units of service or procedure codes to clerical errors made by their billing staffs. In addition, during CYs 2003 through 2005, 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. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[2]

RECOMMENDATIONS

We recommend that Noridian:

- recover the $569,850 in overpayments,

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

- identify and recover any additional overpayments made for high-dollar Part B claims paid after CY 2005.

AUDITEE COMMENTS

In written comments on our draft report, Noridian partially concurred with our first recommendation and concurred with our second recommendation, but did not concur with our third recommendation. With respect to our first recommendation, Noridian concurred that the $569,850 in overpayments should be collected, and described corrective actions taken to date. However, Noridian added that of the eight claims left to collect, two ". . . are outside of the reopening timeliness regulations for contractors."

[2]The carrier sends a "Medicare Summary Notice" to the beneficiary after the provider files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

Noridian concurred with our second recommendation and described corrective actions in progress. Noridian did not, however, concur with our third recommendation. Noridian cited resource constraints, as it estimated that ". . . the number of high dollar claims that would be included in this request would exceed 12,000 claims." Noridian also provided details on its ongoing medical review and data analysis procedures, and added that ". . . this recommendation . . . does not fit with the CMS emphasis for the MACs and carriers to focus medical review efforts on prepay claims review."

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

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing Noridian's written comments, we maintain that our findings and recommendations are valid. With respect to our first recommendation, we disagree with Noridian's statement that two of the remaining uncollected claims are outside of the reopening timeliness regulations for contractors. 42 CFR § 405.980(b) states: "A contractor may reopen and revise its initial determination or redetermination on its own motion. . . . (3) [a]t any time if there exists reliable evidence as defined in §405.902 that the initial determination was procured by fraud or similar fault as defined in §405.902." The term "similar fault" means "to . . . receive Medicare funds to which a person knows or should reasonably be expected to know that he or she . . . is not legally entitled." (Emphasis added.) Therefore we continue to support our first recommendation.

With respect to our third recommendation, we did not intend it to mean that Noridian should conduct a medical review of all high-dollar claims paid after CY 2005, given the fact that only four percent of the claims we reviewed were found to be in error. However, it would be an effective and efficient use of Noridian's medical review resources to analyze the detail data we provided for the 66 claims that were in error, to identify patterns or types of errors in those claims. Noridian could then apply that information to identify any overpayments in high-dollar claims paid after CY 2005. These efforts would take advantage of Noridian's existing medical review structure and would not undermine CMS's emphasis on prepay claims review.

APPENDIX

NORIDIAN®
Administrative Services LLC

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June 30, 2009

Patrick J. Cogley
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Region VII
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Kansas City, MO 64106

RE: Report Number A-07-08-04135

Dear Mr. Cogley:

Thank you for the opportunity to respond to the draft report of the Office of Inspector General (OIG) dated June 4, 2009 entitled, "Review of High-Dollar Payments for Medicare Part B Claims Processed by Noridian Administrative Services, LLC, for the Period January 1, 2003, Through December 31, 2005."

We fully understand the importance of claims payment accuracy, and although just 4% of the claims were found to be overpayments, we agree that overpayments need to be collected as aggressively as possible.

As requested in your letter, here are our responses to the three recommendations that were made:

A. The OIG has recommended that the $569,850 in overpayments on 66 claims be recovered.

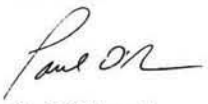
   a. We concur that the overpayments should be collected.
   b. We have recovered payment in full on 51 of the claims.
   c. We have transitioned 7 claims to the appropriate MAC contractors since NAS is no longer responsible for the states in question.
   d. We have 8 claims left to collect. We have sent demand letters for 6 of the claims and are awaiting collections. The two remaining claims are outside of the reopening timeliness regulations for contractors (Internet Only Manual Chapter 3, Sections 70 and 80).

B. The OIG has recommended that NAS use the results of this audit in provider education activities.
   a. We concur with the need for education.
   b. An educational article has been prepared and is in the editing stage with the intent of publishing in the July provider education bulletin.
   c. Messages were sent on June 30, 2009 to providers who participate in the NAS Medicare E-mail List distribution with educational information on: Billing Units Correctly, Documentation Guidelines and Amending Documentation Guidelines.
   d. Related to education, an article was published in the October 2008 provider bulletin giving instruction on CMS publication of "Medical Unlikely Edits," which are closely related to many of the inappropriate claims payments in this report.

C. The OIG has recommended that NAS identify and recover any additional overpayments for high-dollar Part B claims paid after CY 2005.
   a. We do not concur with this recommendation.
   b. Our estimate in terms the number of high dollar claims that would be included in this request would exceed 12,000 claims. This number of claims could consume approximately 80% our medical review resources for a year's worth of funding. We do not have sufficient resources, particularly with the nurse reviewers, to be able to add this workload without additional funding.
   c. Our medical review staff performs reviews on claims that are identified by various means of data analysis and is written into our Medical Review Strategy. However, we will be adding the results of this draft report to the data sources in determining future medical review targets in our strategy.
   d. Another concern we have on this recommendation is that it does not fit with the CMS emphasis for the MACs and carriers to focus medical review efforts on prepay claims review. We recommend that the newly assigned Recovery Audit Contractors (RACs) and Program Safeguard Contractors (PSCs) pursue this postpay claims review since it ties more closely to their scopes of work.

Please advise if additional information is needed or if further clarification is needed on any of our responses.

Sincerely,



Paul O'Donnell
Vice President
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