DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

April 9, 2010

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 Outpatient Services Processed by Noridian Administrative Services, LLC, for the Period January 1, 2003, Through December 31, 2005 (A-07-10-04154)

Attached, for your information, is an advance copy of our final report on high-dollar payments for outpatient services processed by Noridian Administrative Services, LLC (Noridian), for the period January 1, 2003, through December 31, 2005. We will issue this report to Noridian within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact 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 Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-10-04154.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VII
601 East 12th Street, Room 284
Kansas City, MO 64106

April 16, 2010

Report Number: A-07-10-04154

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

Dear Mr. Martinson:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of High-Dollar Payments for Outpatient Services 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-10-04154 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

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

Daniel R. Levinson
Inspector General

April 2010
A-07-10-04154

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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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 aged 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. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

Medicare guidance requires hospitals to claim outpatient services using the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System codes and to report units of service as the number of times that a service or procedure was performed.

During our audit period (calendar years (CY) 2003 through 2005), Noridian Administrative Services, LLC (Noridian), was the fiscal intermediary serving Medicare providers in 11 States. Noridian processed approximately 30.2 million outpatient claims during this period, 104 of which resulted in payments of $50,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that Noridian made to hospitals for outpatient services were appropriate.

SUMMARY OF FINDING

Of the 104 high-dollar payments that Noridian made to hospitals for outpatient services for CYs 2003 through 2005, 27 were appropriate. The 77 remaining payments included overpayments totaling $6,106,260. At the start of our audit, hospitals had refunded overpayments totaling $3,934,036 but had not refunded overpayments totaling $2,172,224.

The hospitals attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during CYs 2003 through 2005 to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that Noridian:

- recover the $2,172,224 in identified overpayments and
- use the results of this audit in its provider education activities.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Noridian's comments are included in their entirety as the Appendix.

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NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 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.[1] 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 hospitals' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

In calendar years (CY) 2003 through 2005, fiscal intermediaries processed and paid approximately 409.4 million outpatient claims, 1,243 of which resulted in payments of $50,000 or more (high-dollar payments).

Claims for Outpatient Services

Medicare guidance requires hospitals to submit accurate claims for outpatient services. Hospitals should use the appropriate Current Procedural Terminology/Healthcare Common Procedure Coding System (CPT/HCPCS) codes and report units of service as the number of times that a service or procedure was performed.[2]

Noridian Administrative Services, LLC

During our audit period (CYs 2003 through 2005), Noridian Administrative Services, LLC (Noridian), was the fiscal intermediary serving Medicare providers in 11 States.[3] Noridian processed approximately 30.2 million outpatient claims during this period, 104 of which resulted in high-dollar payments totaling $8.3 million.

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[1] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 (MMA), 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] CPT/HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

[3] Pursuant to the MMA, Noridian became a Medicare administrative contractor effective July 31, 2006, which was after our audit period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that Noridian made to hospitals for outpatient services were appropriate.

Scope

We reviewed the 104 high-dollar payments for outpatient claims that Noridian processed during CYs 2003 through 2005. We limited our review of Noridian's internal controls to those applicable to the 104 high-dollar 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 fieldwork from July 2007 through April 2009. Our fieldwork included contacting Noridian, located in Fargo, North Dakota, and the hospitals that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient claims with high-dollar Medicare payments;
- reviewed available CWF claim histories for the 104 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 fieldwork;
- contacted the hospitals that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect;
- obtained documentation from the hospitals confirming all incorrect claims identified; and
- coordinated the calculation of overpayments and discussed the results of our review with Noridian.

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 objective.

FINDING AND RECOMMENDATIONS

Of the 104 high-dollar payments that Noridian made to hospitals for outpatient services for CYs 2003 through 2005, 27 were appropriate. The 77 remaining payments included overpayments totaling $6,106,260. At the start of our audit, hospitals had refunded overpayments totaling $3,934,036 but had not refunded overpayments totaling $2,172,224.

The hospitals attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during CYs 2003 through 2005 to prevent or detect the overpayments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. CMS's *Medicare Claims Processing Manual*, Publication 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* states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Hospitals reported excessive units of service or made other billing errors on 34 claims, resulting in overpayments totaling $2,172,224. The claims contained inaccurate data, including incorrect procedure codes and incorrect numbers of billing units of service. The following examples illustrate the billing errors:

- One hospital submitted four claims that incorrectly used the CPT/HCPCS codes for stereotactic radiosurgery instead of the correct codes for stereotactic radiotherapy. This error resulted in a total overpayment of $321,639.

- One hospital billed 145 units of service for CPT code 23410 LT (repair of rotator cuff) when it should have billed 1 unit, resulting in an overpayment of $129,087.

- One hospital billed 50 units of service for HCPCS code J3100 (Tenecteplase 50 mg) when it should have billed 1 unit, resulting in an overpayment of $114,969.

The hospitals attributed the incorrect claims to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.

CAUSES OF INAPPROPRIATE HIGH-DOLLAR PAYMENTS

During CYs 2003 through 2005, Noridian made the incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.[4]

FISCAL INTERMEDIARY PREPAYMENT EDIT

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 claims and requires intermediaries to determine the legitimacy of the claims.

RECOMMENDATIONS

We recommend that Noridian:

- recover the $2,172,224 in identified overpayments and

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

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Noridian's comments are included in their entirety as the Appendix.

[4] The fiscal intermediary sends a *Medicare Summary Notice* to the beneficiary after the hospital 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.

APPENDIX

APPENDIX: NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

NORIDIAN®
Administrative Services LLC

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February 22, 2010

Patrick J. Cogley
Office of Inspector General
Region VII
601 East 12th Street
Room 0429
Kansas City, MO 64106

RE: Report Number A-07-10-04154

Dear Mr. Cogley:

Thank you for the opportunity to respond to the draft report of the U.S. Department of Health & Human Services, Office of Inspector General (OIG) dated January 27, 2010, entitled, *Review of High-Dollar Payments for Outpatient Services Processed by Noridian Administrative Services, LLC, for the Period January 1, 2003, Through December 31, 2005.*

We concur with the recommendation that all overpayments identified ought to be collected. Noridian Administrative Services, LLC, (NAS) has reviewed all claims identified as overpayments by this report. NAS has already collected these overpayments either by provider refund check or adjustment made by the provider.

Additionally, as recommended, we will consider the results of this audit in the analysis of topics for provider education activity.

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

Sincerely,

/s/ Paul O'Donnell

Paul O'Donnell
Vice President
Noridian Administrative Services, LLC