DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

April 27, 2012

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation but Transitioned to Highmark Medicare Services in Jurisdiction 12 for the Period January 1, 2006, Through June 30, 2009 (A-07-11-04184)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by Highmark Medicare Services (Highmark) in Jurisdiction 12. We will issue this report to Highmark 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 Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@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-07-11-04184.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION VII
601 EAST 12TH STREET, ROOM 0429
KANSAS CITY, MO 64106

April 30, 2012

Report Number: A-07-11-04184

Ms. Sandy Coston
Chief Executive Officer
Highmark Medicare Services
1800 Center Street
Camp Hill, PA 17011

Dear Ms. Coston:

Enclosed is the U.S. Department of Health and Human Services, Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation but Transitioned to Highmark Medicare Services in Jurisdiction 12 for the Period January 1, 2006, Through June 30, 2009*. 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-07-11-04184 in all correspondence.

Sincerely,

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

Enclosure

cc:
Mr. E. James Bylotas
Director, Quality and Performance Management

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 355
Kansas City, MO 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION BUT TRANSITIONED TO HIGHMARK MEDICARE SERVICES IN JURISDICTION 12 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

April 2012
A-07-11-04184

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 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 Medicare contractors to process and pay Medicare claims submitted for outpatient services. The Medicare contractors 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 providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description. In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

During our audit period (January 2006 through June 2009), Wisconsin Physicians Service Insurance Corporation (WPS) processed approximately 35.2 million line items for outpatient services in Jurisdiction 12, of which 424 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service. Effective February 2011, the claims that were originally processed by WPS in Jurisdiction 12 were transitioned to Highmark Medicare Services (Highmark). Thus, the 424 line items will be adjudicated by Highmark, and we are issuing our report to Highmark. (A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges.")

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges that WPS made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 424 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 201 were correct. Providers refunded overpayments

on 18 line items totaling $32,031 before our fieldwork. The remaining 205 line items were incorrect and included overpayments totaling $1,508,155, which the providers had not refunded by the beginning of our audit.

Of the 205 incorrect line items:

- Providers reported incorrect units of service on 102 line items, resulting in overpayments totaling $1,274,331.

- Providers used HCPCS codes that did not reflect the procedures performed on 60 line items, resulting in overpayments totaling $131,953.

- Providers billed for unallowable services on 25 line items, resulting in overpayments totaling $68,227.

- Providers did not provide the supporting documentation for 13 line items, resulting in overpayments totaling $25,780.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on five line items, resulting in overpayments totaling $7,864.

The providers 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. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that Highmark:

- recover the $1,508,155 in identified overpayments,

- work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and

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

HIGHMARK MEDICARE SERVICES COMMENTS

In written comments on our draft report, Highmark stated that it was unable to verify the overpayment amounts because access to the WPS workload was no longer available. Highmark added that it would consult with CMS to determine whether any of the overpayments were collected to date and to pursue the possibility of recovery of any outstanding overpayments.

Our draft report included a recommendation related to the recovery of two incorrect line item payments whose line payment amounts had not been determined. In comments on this recommendation, Highmark stated that the two claims could not be adjusted based on the current coding. Highmark stated it would consult with CMS to determine how to address the overpayment amount related to the two claims and recover the funds.

In comments on the last two recommendations, Highmark described corrective actions that it had taken or planned to take.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

With respect to Highmark's comments related to the identified overpayments, we reviewed the remittance advices or the information contained in the Medicare claims processing system for each adjusted line item. In this manner, we were able to confirm not only that the providers had refunded the overpayments, but also the amounts of the overpayments. To verify that the overpayments have been collected, we encourage Highmark to consult with CMS.

When we issued our draft report, 2 of the 205 incorrect line items had not been reprocessed and the correct line payment amounts for those 2 line items had not been determined. Providers have since adjusted the two line items that were outstanding and have subsequently refunded an additional $1,451 to Highmark. After the issuance of our draft report, we identified one line item for which our draft report had understated the questioned cost by $3,028. For this final report, we revised the findings and first recommendation to reflect the additional claim lines adjusted and amounts recovered. We also removed the recommendation involving the two incorrect line items that had been in our draft report.

TABLE OF CONTENTS

INTRODUCTION

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) administers the program. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted for outpatient services.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process providers' outpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description.[2] In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

[2] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

Wisconsin Physicians Service Insurance Corporation

As part of its Legacy Workload, Wisconsin Physicians Service Insurance Corporation (WPS) processed some outpatient claims for Jurisdiction 12 during our audit period (January 2006 through June 2009).[3] Effective February 2011, the Legacy Jurisdiction 12 (Legacy J12) Workload transitioned to Highmark Medicare Services (Highmark), the Medicare contractor for all States in Jurisdiction 12—Delaware, Maryland, New Jersey, and Pennsylvania—as well as the District of Columbia.[4] Thus, the Legacy J12 claims that were originally processed by WPS will be adjudicated by Highmark, and we are issuing our report to Highmark. During our audit period, WPS processed 35.2 million line items for outpatient services that were transitioned to Highmark.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges that WPS made to providers for outpatient services were correct.

Scope

Of the approximately 35.2 million line items for outpatient services that WPS processed during the period January 2006 through June 2009, 424 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service.[5]

We limited our review of WPS's and Highmark's internal controls to those that were applicable to the selected 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.

Our fieldwork included contacting WPS in Omaha, Nebraska, as well as Highmark in Camp Hill, Pennsylvania, and the 31 providers in Jurisdiction 12 that received the selected Medicare payments.

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[3] The WPS Legacy Workload had previously been processed by Mutual of Omaha. The Legacy Workload includes claims submitted by providers who fall under the geographic jurisdiction of all 15 MACs.

[4] The Legacy Workload transition includes a significant number of providers that are Qualified Chain Providers, a designation for providers located over a large geographic area that belong to multiple MAC jurisdictions. A Qualified Chain Provider has the option to move all of its providers, regardless of geographic location, to the MAC that covers the State in which the Qualified Chain Provider's home office is located.

[5] A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges."

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items processed by WPS for providers that billed line items with (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service;[6]
- coordinated with WPS and Highmark in determining the providers and line items associated with the Legacy J12 Workload;
- identified 424 line items totaling approximately $2.1 million that Medicare paid to 31 providers;
- contacted the 31 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with Highmark; and
- discussed the results of our review with Highmark officials on October 24, 2011.

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 424 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 201 were correct. Providers refunded overpayments on 18 line items totaling $32,031 prior to our fieldwork. The remaining 205 line items were incorrect and included overpayments totaling $1,508,155, which the providers had not refunded by the beginning of our audit.

[6] For this audit, we reviewed those line items that met the stated parameters. We applied those parameters to unadjusted line items. In some cases, subsequent payment adjustments reduced the difference between payment and charges to less than $1,000.

Of the 205 incorrect line items:

- Providers reported incorrect units of service on 102 line items, resulting in overpayments totaling $1,274,331.

- Providers used HCPCS codes that did not reflect the procedures performed on 60 line items, resulting in overpayments totaling $131,953.

- Providers billed for unallowable services on 25 line items, resulting in overpayments totaling $68,227.

- Providers did not provide the supporting documentation for 13 line items, resulting in overpayments totaling $25,780.

- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on five line items, resulting in overpayments totaling $7,864.

The providers 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. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

FEDERAL REQUIREMENTS

Section 1833(e) of the Social Security Act states: "No payment shall be made to any provider of services … unless there has been furnished such information as may be necessary in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …."

CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: "providers must use HCPCS codes … for most outpatient services." Chapter 25, section 75.5, of the Manual states: "… when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed." [7] If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 …."

Chapter 1, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

[7] Before CMS Transmittal 1254, Change Request 5593, dated May 25, 2007, and effective June 11, 2007, this provision was located at chapter 25, section 60.5, of the Manual.

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported an incorrect number of units of service on 102 line items, resulting in overpayments totaling $1,274,331. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for 59 line items with an incorrect number of service units. Rather than billing between 25 and 87 service units (the correct range for the HCPCS codes associated with these line items), the provider billed 160 service units. These errors occurred because of an error in the provider's pharmacy billing system. As a result of these errors, WPS paid the provider $496,020 when it should have paid $96,188, an overpayment of $399,832.

- Another provider billed Medicare for an incorrect number of service units on one line item. Rather than billing 12 service units, the provider billed 692 service units. This error occurred because of an error in the provider's billing system. As a result of this miscalculation, WPS paid the provider $217,980 when it should have paid $3,038, an overpayment of $214,942.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 60 line items, resulting in overpayments totaling $131,953. The following examples illustrate the incorrect HCPCS codes:

- Because of an error in the chargemaster,[8] 1 provider billed Medicare for 49 line items with an incorrect HCPCS code. The provider billed for a procedure to separate blood into its components rather than a procedure to transfuse blood. As a result of these errors, WPS paid the provider $80,061. The provider refunded the entire payment of $80,061.

- Another provider billed Medicare for one line item with a HCPCS code (J9216) for the injection of protein, rather than using the correct HCPCS code (J2916) for the injection of sodium ferric gluconate complex that was actually administered. As a result of this error, WPS paid the provider $2,453 when it should have paid $204, an overpayment of $2,249.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for 25 line items for which the services rendered were not allowable for Medicare reimbursement, resulting in overpayments totaling $68,227. For example, 1 provider billed Medicare for 13 line items that were unrelated to outpatient services. Specifically, the provider incorrectly billed Medicare outpatient services for dental procedures that are not covered by Medicare. For one such procedure, the provider billed for the surgical

[8] A provider's chargemaster contains data on every chargeable item or procedure that the provider offers.

removal of an erupted tooth, which is not a covered procedure according to the *Medicare Benefit Policy Manual* (Pub. No. 100-02, chapter 15, section 150). As a result of these errors, WPS paid the provider $34,044 when it should have paid $0, an overpayment of $34,044.

Unsupported Services

Two providers billed Medicare for 13 line items for which they did not provide supporting documentation. Both providers agreed to cancel the claims associated with these line items and refund the combined $25,780 of overpayments received.

Combination of Incorrect Number of Units of Service and Incorrect Healthcare Common Procedure Coding System Codes

Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on five line items. These errors resulted in overpayments totaling $7,864.

For example, one provider billed Medicare for both an incorrect number of units of service and incorrect HCPCS codes on two line items. Rather than billing for one service unit of a laparoscopy procedure, the provider billed between three and four service units of an osteoplasty procedure. As a result of these errors, WPS paid the provider $5,832 when it should have paid $2,951, an overpayment of $2,881.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers 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. WPS made these 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 providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.[9]

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires Medicare contractors to determine the legitimacy of the claims. However, this edit did not detect the errors that we found because the edit considers only the amount of the payment, suspends only those payments that exceed the threshold, and does not flag payments that exceed charges.

[9] The Medicare contractor sends a *Medicare Summary Notice*—an explanation of benefits—to the beneficiary after the provider files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

RECOMMENDATIONS

We recommend that Highmark:

- recover the $1,508,155 in identified overpayments,

- work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and

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

HIGHMARK MEDICARE SERVICES COMMENTS

In written comments on our draft report, Highmark stated that it was unable to verify the overpayment amounts because access to the WPS workload was no longer available. Highmark added that it would consult with CMS to determine whether any of the overpayments were collected to date and to pursue the possibility of recovery of any outstanding overpayments.

Our draft report included a recommendation related to the recovery of two incorrect line item payments whose line payment amounts had not been determined. In comments on this recommendation, Highmark stated that the two claims could not be adjusted based on the current coding. Highmark stated it would consult with CMS to determine how to address the overpayment amount related to the two claims and recover the funds.

In comments on the last two recommendations, Highmark described corrective actions that it had taken or planned to take.

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

OFFICE OF INSPECTOR GENERAL RESPONSE

With respect to Highmark's comments related to the identified overpayments, we reviewed the remittance advices or the information contained in the Medicare claims processing system for each adjusted line item. In this manner, we were able to confirm not only that the providers had refunded the overpayments, but also the amounts of the overpayments. To verify that the overpayments have been collected, we encourage Highmark to consult with CMS.

When we issued our draft report, 2 of the 205 incorrect line items had not been reprocessed and the correct line payment amounts for those 2 line items had not been determined. Providers have since adjusted the two line items that were outstanding and have subsequently refunded an additional $1,451 to Highmark. After the issuance of our draft report, we identified one line item for which our draft report had understated the questioned cost by $3,028. For this final report, we revised the findings and first recommendation to reflect the additional claim lines adjusted and amounts recovered. We also removed the recommendation involving the two incorrect line items that had been in our draft report.

APPENDIX

APPENDIX: HIGHMARK MEDICARE SERVICES COMMENTS

January 6, 2012

RE: Report Number A-07-11-04184

Patrick J. Cogley
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

Dear Mr. Cogley,

This letter is in response to your letter dated December 9, 2011, regarding the draft report for audit number A-07-11-04184, *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Highmark Medicare Services in Jurisdiction 12 for the Period January 1, 2006 Through June 30, 2009.*

Recommendation that Highmark *recover the $1,503,677 in identified overpayments:*

Response: HMS conducted preliminary analysis of the report provided by the OIG for the exit conference. We researched 25 line items of the report in order to determine the overpayment amounts. In 16 cases, we were not able to locate the AR's on the J12 WPS workload on HIGLAS because our access to the WPS HIGLAS historical workload is no longer available. In other cases, situations such as the adjusted claim paying the same amount or more than original claim, or providers sending in voluntary refunds to reconcile the balance exist resulting in no overpayment to pursue.

We will consult with CMS to attempt to determine whether any of the overpayments have been collected to date and to pursue possible recovery of any outstanding overpayments, as appropriate.

Recommendation that Highmark *determine the amount of overpayments for the two incorrect line item payments and recover that amount:*

Response: The two claims noted in the report cannot be adjusted based on the current coding in the shared system. A valid HCPC code must be present to enable us to adjust these claims and recover any overpayments. We will consult with CMS to determine how to address the amount of overpayment and recover the funds.

Enclosure (2)

Recommendation that Highmark ***implement system edits that identify line item payments that exceed billed charges by a prescribed amount:***

Response: HMS conducted analysis of this issue related to an OIG audit of claims within the J12 area of responsibility. The issue has been added to Medical Review's annual proactive analytic schedule.

HMS' Informatics area reviews many sources of data for potential issues, including OIG reports. Additionally, CMS has implemented a new quarterly reporting process which identifies specific vulnerabilities for the Contractor to address. The issues on this OIG report and recent RAC findings can be included on in the quarterly process.

Recommendation that Highmark ***use the results of this audit in its provider education activities:***

Response: HMS will use the findings listed to develop targeted provider education opportunities. As appropriate, HMS will send CBRs (Comparative Billing Reports) to providers. The CBRs will instruct the providers on proper billing and allow them to review their claims and repay monies in the case of errors.

If there are any other questions or concerns, please do not hesitate to contact me at (717) 302-4410 or Michele Daley-Ryan at (717) 302-7516.

Sincerely,

E. James Bylotas
Director, Quality and Performance Management
Highmark Medicare Services