



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

September 10, 2007

Report Number: A-05-07-00065

Mr. Michael McCarron, President  
National Government Services  
(Formerly known as AdminaStar Federal)  
8115 Knue Road  
Indianapolis, IN 46207

Dear Mr. McCarron:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Excessive Payments for Outpatient Services Processed by National Government Services for Calendar Years 2004 and 2005 – Illinois, Indiana, Kentucky and Ohio." 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 principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it 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 (312) 353-2618 or through e-mail at [Marc.Gustafson@oig.hhs.gov](mailto:Marc.Gustafson@oig.hhs.gov), or Stephen Slamar, Audit Manager, at (312) 353-7905 or through e-mail at [Stephen.Slamar@oig.hhs.gov](mailto:Stephen.Slamar@oig.hhs.gov). Please refer to report number A-05-05-00065 in all correspondence.

Sincerely,

Marc Gustafson  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Jackie Garner  
Regional Administrator  
Centers for Medicare & Medicaid Services  
U.S. Department of Health and Human Services  
233 North Michigan Ave, Suite 600  
Chicago, IL 60601

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF EXCESSIVE  
PAYMENTS FOR OUTPATIENT  
SERVICES PROCESSED BY  
NATIONAL GOVERNMENT  
SERVICES FOR CALENDAR YEARS  
2004 AND 2005— ILLINOIS,  
INDIANA, KENTUCKY AND OHIO**



Daniel R. Levinson  
Inspector General

September 2007  
A-05-07-00065

# ***Office of Inspector General***

<http://oig.hhs.gov>

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

## **OAS FINDINGS AND OPINIONS**

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

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately using proper Health Care Common Procedure Coding System (HCPCS) codes and reporting units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

National Government Services is a Medicare Part A intermediary serving Medicare providers in Illinois, Indiana, Kentucky and Ohio. For claims with dates of services in calendar years 2004 and 2005, National Government Services processed 79 outpatient claims that had payments of \$50,000 or more.

### **OBJECTIVE**

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

### **SUMMARY OF FINDINGS**

Most of the high-dollar Medicare outpatient payments were not appropriate. For calendar years 2004 and 2005 claims, National Government Services made 79 payments of \$50,000 or more for outpatient services. Our analysis indicated that only 13 payments were correct and the remaining 66 payments were inappropriate. We determined that, at the start of our fieldwork in May 2007:

- Fifty-three payments, totaling \$3,338,895, had been refunded by the providers.
- Thirteen payments, totaling \$513,796, remained outstanding.

The inappropriate payments were made because providers claimed incorrect units of service in 54 instances, incorrect HCPCS codes in 6 instances, and a combination of incorrect HCPCS codes and units of service in 6 instances. National Government Services made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar years 2004 or 2005 to detect billing errors related to HCPCS codes and the units of services.

## **RECOMMENDATIONS**

We recommend that National Government Services:

- inform us of the status of the recovery of the \$513,796 in overpayments that our audit identified,
- identify and recover additional overpayments made on high-dollar outpatient claims paid after calendar year 2005, and
- use the results of this audit in its provider education activities.

## **NATIONAL GOVERNMENT SERVICES' COMMENTS**

In written comments on the draft report, National Government Services agreed with our recommendations. We have included National Government Services' comments as an appendix to the report.

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 <b>NATIONAL GOVERNMENT SERVICES' COMMENTS</b>	

# INTRODUCTION

## BACKGROUND

### **Fiscal Intermediary Responsibilities**

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

### **Claims for Outpatient Services**

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately using proper Health Care Common Procedure Coding System (HCPCS) codes and reporting units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

The Social Security Act's definition of "provider of services" encompasses hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, renal dialysis facilities, and hospice programs. However, our audit was limited to claims submitted by hospitals; thus, the term "provider" as used throughout this report refers to hospitals.

### **National Government Services**

During our audit periods of calendar years 2004 and 2005, AdminaStar Federal was the fiscal intermediary in Illinois under CMS contract number 00131, Indiana under CMS contract number 000130, Kentucky under CMS contract number 000160, and Ohio under CMS contract number 00332. In January 2007, AdminaStar Federal became National Government Services.<sup>1</sup>

The name "National Government Services" used throughout this report refers to the fiscal intermediary formerly known as AdminaStar Federal.

### **Fiscal Intermediary Edits**

During our audit period of calendar years 2004 and 2005, National Government Services had a prepayment edit in place to suspend outpatient claims with reported charges exceeding \$50,000. For the suspended claims, National Government Services contacted providers to verify the correctness of the charges.

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<sup>1</sup>AdminaStar Federal, Anthem Health Plans of New Hampshire, Inc., Associated Hospital Service, Empire Medicare Services, and United Government Services combined operations and became National Government Services.

On January 3, 2006, after the end of 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 outpatient claims with reimbursement of \$50,000 or more and requires intermediaries to contact providers to determine the legitimacy of the claims.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

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

### **Scope**

We reviewed the 79 outpatient claims for which National Government Services Paid \$50,000 or more each in calendar years 2004 and 2005. We limited our review of National Government Services' internal control structure to those controls applicable to the 79 claims because our objective did not require an understanding of all internal controls over claims submission or claims processing. Our review allowed us to establish a reasonable assurance regarding 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 fieldwork at National Government Services' office in Chicago from May through July 2007.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations;
- used CMS's National Claims History file to identify outpatient claims with Medicare payments of \$50,000 or more;
- reviewed available Common Working File claims histories for claims of \$50,000 or more to determine whether those claims had been canceled and superseded by a revised claim or whether the payments remained outstanding at the time of our fieldwork;
- contacted the providers with outstanding payments to determine whether the units of service shown on the claims were correct and, if not, why the claims were billed in error and whether the providers agreed that a refund was appropriate; and
- coordinated our review with National Government Services.

We conducted our review in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

Most of the high-dollar Medicare outpatient payments were not appropriate. For calendar years 2004 and 2005 claims, National Government Services made 79 payments of \$50,000 or more for outpatient services. Our analysis indicated that only 13 payments were correct and the remaining 66 payments were inappropriate. We determined that, at the start of our fieldwork in May 2007:

- Fifty-three payments, totaling \$3,338,895, had been refunded by the providers.
- Thirteen payments, totaling \$513,796, remained outstanding.

The inappropriate payments were made because providers claimed incorrect units of service in 54 instances, incorrect HCPCS codes in 6 instances, and a combination of incorrect HCPCS codes and units of service in 6 instances. National Government Services made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar years 2004 or 2005 to detect billing errors related to HCPCS codes and the units of services.

### **FEDERAL REQUIREMENTS**

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the HCPCS. Section 3627.8(C) of the "Medicare Intermediary Manual" states: "The definition of service units is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the number of times the service or procedure being reported was performed. Furthermore, the "Hospital Manual," section 462, states: "In order to be paid 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 CLAIMS SUBMISSIONS**

Of the 79 claims for \$50,000 or more, 66 resulted in inappropriate payments. The following examples illustrate inappropriate payments:

- A provider incorrectly billed J3487 code description rather than Q0137 code description for the injection of the drug, Darbepoetin alpha. National Government Services overpaid approximately \$77,000.
- A provider incorrectly billed 112 units (the number of minutes in the operating room) rather than 8 units of fifteen minute increments for an arteriovenous grafting. National Government Services overpaid approximately \$73,000.

- A provider incorrectly billed 840 units of the immune globulin drug, Sandoglobulin rather than 42 units, due to an incorrect dosage conversion. National Government Services overpaid approximately \$57,000.

Our analysis showed that the 66 claims for calendar years 2004 and 2005 contained overpayments totaling \$3,852,691. As of the May 2007 start of our fieldwork, the providers had refunded 53 overpayments totaling \$3,338,895. We gave the remaining 13 claims, which accounted for \$513,796 of the total overpayments, to both National Government Services and the providers for correction.

## **CAUSES OF OVERPAYMENTS**

The providers agreed that overpayments occurred on the claims and that a refund was due or has already been made. The providers attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent incorrect billing of HCPCS codes and units of service.

In addition, during calendar years 2004 and 2005, neither National Government Services nor the Common Working File had sufficient prepayment controls. National Government Services' prepayment edits were limited to screening claims exceeding the threshold of \$50,000 in reported charges. Because these edits focused on charges rather than the payment amount, claims with payment amounts of \$50,000 or more that had charges below the threshold were not subject to the edits allowing inappropriate payments to go undetected. Further, the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments to providers. In effect, Medicare relied on providers to notify the intermediaries of some of the excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments made to providers.

## **RECOMMENDATIONS**

We recommend that National Government Services:

- inform us of the status of the recovery of the \$513,796 in overpayments that our audit identified,
- identify and recover additional overpayments made on high-dollar outpatient claims paid after calendar year 2005, and
- use the results of this audit in its provider education activities.

## **NATIONAL GOVERNMENT SERVICES' COMMENTS**

In written comments on the draft report, National Government Services agreed with our recommendations. We have included National Government Services' comments as an appendix to the report.

# **APPENDIX**



8115 Knue Road  
Indianapolis, Indiana 46250-1936  
www.NGS Medicare.com

A CMS Contracted Agent

## Medicare

August 30, 2007

Mr. Marc Gustafson  
Regional Inspector General for Audit Services  
Office of Inspector General, Region V  
233 North Michigan Avenue  
Chicago, IL 60601

RE: Response to Draft Report Number A-05-07-00065

Dear Mr. Gustafson:

This letter is in response to the above referenced draft report entitled "Review of Excessive Payments for Outpatient Services Processed by National Government Services for Calendar Years 2004 and 2005 -- Illinois, Indiana, Kentucky and Ohio."

We agree with the audit recommendations noted in the draft report. We have already processed the adjustments to recover the overpayments identified during the audit and will provide further outreach and education to providers on the issues identified in the report. In addition, as noted in the audit report, an edit was implemented within the Fiscal Intermediary Standard System in January 2006 to suspend outpatient claims with a reimbursement of \$50,000 or more for further review and follow-up with providers to determine the legitimacy of the claims.

We would also like to provide clarification with respect to the section entitled Fiscal Intermediary Edits. This section indicates that National Government Services had a prepayment edit in place to suspend outpatient claims with reported charges exceeding \$50,000, which is accurate. However, it goes on to state that the edit was also in place for reported units of service exceeding 50,000 and this statement is inaccurate and should be removed from the report.

This section also discusses the Fiscal Intermediary Standard System edit that was implemented in January 2006. We would suggest that the sentence which states "This edit suspends outpatient claims of \$50,000 or more..." be revised to include the following language "This edit suspends outpatient claims with reimbursement of \$50,000 or more..."

Thank you for the opportunity to respond to the draft report. If you have any additional questions, please feel free to contact Cheryl Leissing, Part A Claims Director, at 414-459-5884.

Sincerely,

Christine Beard  
Regional Vice President, Claims and Operations

cc: Cheryl Leissing, Part A/RHHI Claims Director  
Sarah Literal, Part A/RHHI Claims Director

