



Office of Audit Services, Region III
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Philadelphia, PA 19106-3499

AUG 14 2009

Report Number: A-03-07-00011

Mr. Patrick Kiley
President
Highmark Medicare Services
1800 Center Street
Camp Hill, Pennsylvania 17089

Dear Mr. Kiley:

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 Outpatient Claims Processed by Highmark Medicare Services for Calendar Years 2003–2005." 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 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, 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 (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through email at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-07-00011 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky
Regional Inspector General
for Audit Services

Enclosure

Copy:
Mr. Jamie Bylotas
Director, Quality & Performance Management

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
OUTPATIENT CLAIMS
PROCESSED BY
HIGHMARK MEDICARE SERVICES
FOR CALENDAR YEARS 2003–2005**



Daniel R. Levinson
Inspector General

August 2009
A-03-07-00011

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 fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments (providers). The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process payments for claims. The Common Working File can detect certain improper payments during prepayment validation.

Medicare guidance requires providers to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of service as the number of times that a service or procedure was performed.

Highmark Medicare Services (Highmark), formerly Veritus Medicare Services, was the Medicare fiscal intermediary for Pennsylvania during calendar years (CY) 2003–2005. Highmark processed more than 19 million outpatient claims for Pennsylvania, 31 of which resulted in payments of \$50,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 31 high-dollar payments that Highmark made to providers, 29 were inappropriate. Of the 29 payments, 28 included overpayments totaling \$2,148,343. Providers refunded \$1,215,675 of this amount prior to our audit and \$300,518 as a result of our audit. Providers had not refunded \$632,150 in overpayments for seven claims at the time of our audit. For the remaining payment, we were unable to review the claim because it was included in an investigation by the U. S. Department of Justice.

Providers received these overpayments by billing excessive charges or by billing for excessive units of service. Highmark made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CY 2003–2005 to detect and prevent the overpayments.

RECOMMENDATIONS

We recommend that Highmark:

- recover \$632,150 for the seven identified overpayments and
- use the results of this audit in its provider education activities.

HIGHMARK MEDICARE SERVICES COMMENTS

In comments on our draft report (see Appendix), Highmark stated that it concurred with our recommendations and will initiate action to recover the \$632,150 in identified overpayments. Highmark also brought to our attention a technical correction regarding the payment methodology used to calculate the payment for one claim that we have amended in the report.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Fiscal Intermediaries.....	1
Claims for Outpatient Services.....	1
Highmark Medicare Services.....	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	2
FINDINGS AND RECOMMENDATIONS	3
FEDERAL REQUIREMENTS	3
INAPPROPRIATE HIGH-DOLLAR PAYMENTS	3
Excessive Units of Service Billed.....	3
Excessive Units of Service Billed and Incorrect Rate Used.....	4
CAUSES OF OVERPAYMENTS	5
FISCAL INTERMEDIARY PREPAYMENT EDIT	5
RECOMMENDATIONS	5
HIGHMARK MEDICARE SERVICES COMMENTS	5
APPENDIX	
HIGHMARK MEDICARE SERVICES COMMENTS	

INTRODUCTION

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) 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 (providers). 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 providers' claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments during prepayment validation.

In calendar years (CY) 2003–2005, fiscal intermediaries processed and paid more than 409 million outpatient claims, 1,243 of which resulted in payments of \$50,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

Claims for Outpatient Services

Providers generate the claims for outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of service as the number of times that the service or procedure was performed.

Highmark Medicare Services

Highmark Medicare Services (Highmark), formerly Veritus Medicare Services, was the Medicare fiscal intermediary for Pennsylvania during CYs 2003–2005.¹ Highmark processed more than 19 million outpatient claims for Pennsylvania, 31 of which resulted in high-dollar payments.

¹Veritus Medicare Services began operating as Highmark Medicare Services on July 1, 2006. Highmark Medicare Services, a subsidiary of Highmark Inc, is headquartered in Pittsburgh and has offices in Camp Hill and Williamsport, Pennsylvania.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 31 high-dollar payments for outpatient claims that Highmark processed for Pennsylvania providers during CY 2003–2005. We limited our review of Highmark’s internal controls to those applicable to the 31 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 our audit work from March 2008 through June 2009. Our audit included contacting Highmark and the 16 providers that received the 31 high-dollar Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS’s National Claims History file to identify outpatient 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 payments remained outstanding at the time of our audit;
- contacted the providers that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect; and
- coordinated the calculation of overpayments and discussed the results of our review 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 findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 31 high-dollar payments that Highmark made to providers, 29 were inappropriate. Of the 29 payments, 28 included overpayments totaling \$2,148,343. Providers refunded \$1,215,675 of this amount prior to our audit and \$300,518 as a result of our audit. Providers had not refunded \$632,150 in overpayments for seven claims at the time of our audit. For the remaining payment, we were unable to review the claim because it was included in an investigation by the U. S. Department of Justice.²

Providers received these overpayments by billing excessive charges or by billing for excessive units of service. Highmark made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CY 2003–2005 to detect and prevent the overpayments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires providers to report claims for outpatient services using Healthcare Common Procedure Coding System codes. CMS's "Medicare Claims Processing Manual," (the Manual) Pub 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 the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" requires the fiscal intermediary to maintain adequate internal controls over Medicare automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Highmark made seven overpayments that providers had not refunded at the time of our audit. For all seven overpayments, providers billed Highmark for excessive units of service. For one of these claims, Highmark calculated the payment at an incorrect rate, which resulted in a higher overpayment. In total, for claims that providers had not refunded at the time of our audit, Highmark paid \$1,087,292 when it should have paid \$455,142, resulting in overpayments of \$632,150.

Excessive Units of Service Billed

For six of the seven overpayments, the providers billed Highmark for more units of service than were performed. As a result, Highmark paid \$ 419,569, when it should have paid \$ 63,030, resulting in an overpayment of \$356,539

²The payment was part of a U. S. Department of Justice investigation that alleged the provider submitted erroneous claims. The provider denied wrong doing but reached an agreement with the Government that included a monetary settlement. Due to that investigation and agreement, we were unable to determine whether the high-dollar payment Highmark made for that claim was proper.

- For four of the overpayments, the provider billed Highmark for 10 times the number of units of cetuximab, a cancer treatment drug, than were administered. As a result, Highmark overpaid the provider \$280,943.
- For one of the overpayments, the provider billed Highmark for 84 laser vaporization services instead of 1 service. As a result, Highmark overpaid the provider \$55,399.
- For one of the overpayments, the provider incorrectly billed Highmark for the replacement/insertion of a neurostimulator, a service that was not performed. As a result, Highmark overpaid the provider \$20,197.

Excessive Units of Service Billed and Incorrect Rate Used

The Manual, chapter 3, section 20.7-3, allows hospitals to receive “a special add-on payment for the costs of furnishing blood clotting factors to Medicare beneficiaries with hemophilia, admitted as inpatients of PPS [prospective payment system] hospitals. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS code long description) billed by the provider under special instructions for units of service.”

For the remaining overpayment, the provider submitted an inpatient claim for a beneficiary with hemophilia, that included charges for blood clotting factors. Highmark could not process the total claim because its value exceeded the limit of the Fiscal Intermediary Standard System. CMS therefore directed Highmark to pay part of the claim as an inpatient claim and the balance as an outpatient claim.

Highmark paid the prospective payment system portion of the claim and the add-on payments for the two clotting factors included on the inpatient claim in accordance with the Manual. The inpatient claim included charges for 546 units of Factor VIIa (HCPCS code Q0187) that were paid \$1,077.23 per unit. In total, the provider billed for 1,091 units of clotting Factor VIIa; however, 1,091 was the number of milligrams administered to the patient not the number of billable units. Using the conversion factor³ defined in the HCPCS code long descriptor, 1,091 milligrams is equivalent to 910 billable units.

Consequently, for the portion of the claim that was paid as an auxiliary outpatient claim:

- the provider incorrectly billed for 181 more units (1,091 less 910) than administered and
- Highmark relied on verbal instructions from CMS that resulted in using an incorrect payment methodology to calculate the payment.

As a result of these errors, Highmark paid the provider \$667,723 when it should have paid a total of \$392,112, resulting in an overpayment of \$275,611.

³One billable unit of Factor VIIa is equal to 1.2 milligrams administered.

CAUSES OF OVERPAYMENTS

The providers attributed the incorrect payments to clerical errors made by their billing staffs and to problems with incorrect data in their billing systems. In addition, during CY 2003–2005, Highmark did not have prepayment or postpayment controls to identify overpayments at the payment level, and the Common Working File prepayment process lacked edits to detect and prevent excessive payments. In effect, CMS relied on providers to notify the 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 payments and requires intermediaries to determine the legitimacy of the payments.

Highmark stated that it had an edit in place during our audit period that suspended for prepayment review all claims with payment amounts greater than \$150,000. Beginning January 3, 2006, Highmark reduced their edit limit to payment amounts greater than \$50,000. Highmark reviewed claims that exceeded the limit and verified the units and amount billed with the providers. If the providers verified that the units and amount billed were correct, Highmark processed the claims. If the providers did not verify the units and amount billed, Highmark returned the claims to the providers for correction.

RECOMMENDATIONS

We recommend that Highmark:

- recover \$632,150 for the seven identified overpayments, and
- use the results of this audit in its provider education activities.

HIGHMARK MEDICARE SERVICES COMMENTS

In comments on our draft report, Highmark stated that it concurred with our recommendations and will initiate action to recover the \$632,150 in identified overpayments. Highmark also brought to our attention a technical correction regarding the payment methodology used to calculate the payment for one claim that we have amended in the report. Highmark’s comments are included in the Appendix.

⁴The fiscal intermediary sends a “Medicare Summary Notice” to the beneficiary after the hospital files a claim for outpatient services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX



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

August 11, 2009

OIG Report Number: A-03-07-0011

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 Hospital Outpatient Claims Processed by Highmark Medicare Services for the Calendar Years 2003-2005."

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

Sincerely,

A handwritten signature in cursive script that reads "E. James Bylotas".

E. James Bylotas
Director, Quality and Performance Management

CC: Bernard Siegel

Highmark Medicare Services
Response to OIG Audit A-03-07-0011

I. Inappropriate High-Dollar Payments

"Highmark made seven overpayments that providers had not refunded at the time of our audit. For all seven overpayments, providers billed Highmark for excessive units of service. For one of these claims, Highmark calculated the payment at an incorrect rate, which resulted in a higher overpayment. In total, for claims that providers had not refunded at the time of our audit, Highmark paid \$1,087,292 when it should have paid \$455,142, resulting in overpayments of \$632,150.

Excessive Units of Service Billed

For six of the seven overpayments, the providers billed Highmark for more units of service than were performed. As a result, Highmark paid \$ 419,569, when it should have paid \$63,030, resulting in an overpayment of \$356,539

Excessive Units of Service Billed and Incorrect Rate Used

The Manual, chapter 3, section 20.7-3, allows hospitals to receive "a special add-on payment for the costs of furnishing blood clotting factors to Medicare beneficiaries with hemophilia, admitted as inpatients of PPS [prospective payment system] hospitals. The clotting factor add-on payment is calculated using the number of units (as defined in the HCPCS [Healthcare Common Procedure Coding System] code long descriptor) billed by the provider under special instructions for units of service."

For the remaining overpayment, the provider submitted an inpatient claim for a beneficiary with hemophilia, that included charges for blood clotting factors. Highmark could not process the total claim because its value exceeded the limit of the Fiscal Intermediary Standard System. CMS therefore directed Highmark to pay part of the claim as an inpatient claim and the balance as an outpatient claim.

Highmark paid the prospective payment system portion of the claim and the add-on payments for the two clotting factors included on the inpatient claim in accordance with the Manual. The inpatient claim included charges for 546 units of Factor VIIa (HCPCS code Q0187) that were paid \$1,077.23 per unit. In total, the provider billed for 1,091 units of clotting Factor VIIa; however, 1,091 was the number of milligrams administered to the patient not the number of billable units. Using the conversion factor defined in the HCPCS code long descriptor, 1,091 milligrams is equivalent to 910 billable units. Consequently, for the portion of the claim that was paid as an auxiliary outpatient claim:

- the provider incorrectly billed for 181 more units (1,091 less 910) than administered and
- Highmark used the incorrect payment methodology to calculate the payment.

As a result of these errors, Highmark paid the provider \$667,723 when it should have paid a total of \$392,112, resulting in an overpayment of \$275,611."

Recommendation

"We recommend Highmark recover the \$632,150 for the seven identified overpayments."

Highmark Medicare Services Response

We accept this recommendation. Upon receipt of the claim detail information, we will initiate activity to recover the \$632,150 for the seven identified overpayments.

HMS disagrees with the OIG observation that Highmark calculated the payment at the incorrect rate. For the claim in question, the provider submitted the claim with the excessive units of service billed. At the time this claim was processed, the CMS standard system did not permit the coding of the total services billed on a single line. Highmark received verbal instructions from CMS on which we relied to process the claim.

Recommendation

"We recommend that Highmark use the results of this audit in its provider education activities."

Highmark Medicare Services Response

Highmark Medicare Services concurs with this recommendation and will include the results of this audit in our analysis of provider education activities. 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. This information is used as a resource in determining provider education activities.