



September 9, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /Lori S. Pilcher/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services
Processed by Noridian Administrative Services, LLC, in Jurisdiction 6 –
Minnesota for the Period January 1, 2006, Through June 30, 2009
(A-05-10-00020)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by Noridian Administrative Services, LLC (Noridian), in Jurisdiction 6 – Minnesota. 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 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 Sheri L. Fulcher, Acting Regional Inspector General for Audit Services, Region V, at (312) 353-7905 or through email at Sheri.Fulcher@oig.hhs.gov. Please refer to report number A-05-10-00020.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

September 14, 2011

Report Number: A-05-10-00020

Mr. Michael Hamerlik
President and Chief Executive Officer
Noridian Administrative Services, LLC
900 42nd Street South
Fargo, ND 58103

Dear Mr. Hamerlik:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 6 – Minnesota 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 contact me at (312) 353-1823 or through email at Sheri.Fulcher@oig.hhs.gov. Please refer to report number A-05-10-00020 in all correspondence.

Sincerely,

/Sheri L. Fulcher/
Acting 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 and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
EXCEEDING CHARGES FOR
OUTPATIENT SERVICES
PROCESSED BY NORIDIAN
ADMINISTRATIVE SERVICES, LLC,
IN JURISDICTION 6 — MINNESOTA
FOR THE PERIOD JANUARY 1, 2006,
THROUGH JUNE 30, 2009**



Daniel R. Levinson
Inspector General

September 2011
A-05-10-00020

Office of Inspector General

<http://oig.hhs.gov>

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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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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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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 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 units administered. 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.

Noridian Administrative Services, LLC (Noridian), has been the fiscal intermediary for the State of Minnesota since August 1999. On January 7, 2009, CMS awarded the Medicare Administrative Contractor contract for Jurisdiction 6, which includes Minnesota; however, protests were filed against the award. CMS is taking corrective action on the award. In the meantime, Noridian, acting as the legacy fiscal intermediary, continues to process claims for providers in Minnesota. During our audit period (January 2006 through June 2009), approximately 46.9 million line items for outpatient services were processed for Minnesota, of which 520 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. (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 Noridian made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 520 selected line items for which Noridian made Medicare payments to providers for outpatient services during our audit period, 59 were correct. Providers refunded overpayments on 94 line items totaling \$2,550,380 before our fieldwork. The 367 remaining line items were incorrect. Of these 367 line items, 363 included overpayments totaling \$3,566,189, which the providers had not refunded by the beginning of our audit. As of July 25, 2011, the amount of overpayment for the four remaining incorrect line items had not been determined because the line items had not been reprocessed and the correct line payment amounts identified.

Of the 367 incorrect line items:

- Providers reported incorrect units of service on 229 line items, resulting in identified overpayments totaling at least \$2,619,756 (the amount of overpayment for 4 of the 229 line items has not been determined).
- Providers billed for unallowable services on 111 line items, resulting in identified overpayments totaling \$527,414.
- Providers did not provide the supporting documentation for six line items, resulting in identified overpayments totaling \$307,757.
- Providers used HCPCS codes that did not reflect the procedures performed on 13 line items, resulting in overpayments totaling \$91,778.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on eight line items, resulting in overpayments totaling \$19,484.

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. Noridian 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 Noridian:

- recover \$3,566,189 in identified overpayments,
- determine the amount of overpayment for the four incorrect line item payments and recover that amount,

- 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.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it has taken or plans to take. In our draft report, we recommended that Noridian determine and recover the overpayments associated with 26 incorrect line items that we identified. In its comments, Noridian stated that it had collected overpayments totaling \$75,119 associated with 18 of those line items. After submitting its written comments, Noridian provided additional information that showed it had collected an additional \$58,924 associated with four of the eight remaining line items. Accordingly, we have revised our findings and our first two recommendations to reflect the additional claim lines adjusted and amounts recovered.

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

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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.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare 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 units administered.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.

Noridian Administrative Services, LLC

Noridian Administrative Services, LLC (Noridian), has been the fiscal intermediary for the State of Minnesota since August 1999. On January 7, 2009, CMS awarded the Medicare Administrative Contractor contract for Jurisdiction 6, which includes Minnesota; however, protests were filed against the award. CMS is taking corrective action on the award. In the meantime, Noridian, acting as the legacy fiscal intermediary, continues to process claims for providers in Minnesota. During our audit period (January 2006 through June 2009), approximately 46.9 million line items for outpatient services were processed for Minnesota providers.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the approximately 46.9 million line items for outpatient services that Noridian processed during the period January 2006 through June 2009, we reviewed 520 line items that 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.³

We limited our review of Noridian'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 Noridian, in Fargo, North Dakota, and the 42 providers⁴ in Minnesota that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

³ A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review the entire claim; 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."

⁴ One provider refunded overpayments on all three selected line items before our fieldwork; therefore, we did not contact that provider.

- used CMS’s National Claims History file to identify outpatient line items in which (1) Medicare line payment amounts exceeded the line billed charge amounts by at least \$1,000 and (2) the line item had 3 or more units of service;⁵
- identified 520 line items totaling approximately \$6.6 million that Medicare paid to 42 providers;
- contacted 41 providers that received Medicare payments for 426 line items⁶ 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 Noridian; and
- discussed the results of our review with Noridian on January 25, 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 520 selected line items for which Noridian made Medicare payments to providers for outpatient services during our audit period, 59 were correct. Providers refunded overpayments on 94 line items totaling \$2,550,380 before our fieldwork. The 367 remaining line items were incorrect. Of these 367 line items, 363 included overpayments totaling \$3,566,189, which the providers had not refunded by the beginning of our audit. As of July 25, 2011, the amount of overpayment for the four remaining incorrect line items had not been determined because the line items had not been reprocessed and the correct line payment amounts identified.

Of the 367 incorrect line items:

- Providers reported incorrect units of service on 229 line items, resulting in identified overpayments totaling at least \$2,619,756 (the amount of overpayment for 4 of the 229 line items has not been determined).

⁵ For this audit, we reviewed those line items that met the stated parameters. We applied these parameters to unadjusted line items. In some cases, subsequent payment adjustments reduced the difference between payments and charges to less than \$1,000.

⁶ We did not review 94 of the 520 selected line items because providers refunded overpayments before our fieldwork.

- Providers billed for unallowable services on 111 line items, resulting in identified overpayments totaling \$527,414.
- Providers did not provide the supporting documentation for six line items, resulting in identified overpayments totaling \$307,757.
- Providers used HCPCS codes that did not reflect the procedures performed on 13 line items, resulting in overpayments totaling \$91,778.
- Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on eight line items, resulting in overpayments totaling \$19,484.

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. Noridian 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.”

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported incorrect units of service on 229 line items, resulting in overpayments totaling at least \$2,619,756. The amount of overpayment for 4 of the 229 line items has not been

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.

determined because the line item has not been reprocessed and the correct line payment amount identified. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for incorrect service units on five line items. Rather than billing 1 service unit (the correct chargeable unit count for the HCPCS codes associated with these line items), the provider billed between 48 and 87 service units. These errors occurred because an electronic billing format conversion procedure was deleted when the provider upgraded its billing software. As a result of these errors, Noridian paid the provider \$110,166 when it should have paid \$2,736, an overpayment of \$107,430.
- Another provider billed Medicare for incorrect service units on nine line items. Rather than billing 1 or 2 service units, the provider billed between 50 and 100 service units. These clerical errors occurred because the coder incorrectly performed the quantity conversion associated with the services. As a result of these errors, Noridian paid the provider \$120,874 when it should have paid \$2,450, an overpayment of \$118,424.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for 111 line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling \$527,414. For example, a provider billed Medicare for 18 line items that were unrelated to outpatient services. 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 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, Noridian paid the provider \$105,286 when it should have paid \$0, an overpayment of \$105,286.

Unsupported Services

Three providers billed Medicare for six line items for which the providers did not provide supporting documentation, resulting in overpayments totaling \$307,757. Two of the providers agreed to cancel two line items and issue a total refund of \$10,933. The remaining provider did not respond to our requests regarding four line items totaling \$296,824.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 13 line items, resulting in overpayments totaling \$91,778. For example, because of a clerical error, a provider billed Medicare for two line items with HCPCS code J2469, an injection used to prevent nausea and vomiting caused by chemotherapy, rather than using the correct HCPCS code J0878, an antibiotic injection used to treat serious infection. As a result of this error, Noridian paid the provider \$15,216 when it should have paid \$220, an overpayment of \$14,996.

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

Providers reported a combination of incorrect units of service claimed and incorrect HCPCS codes on eight line items, resulting in overpayments totaling \$19,484. For example, because of a clerical error, one provider billed Medicare for 14 units of a critical care procedure with HCPCS code 99291 rather than 1 unit of a level 5 emergency room procedure with HCPCS code 99285. As a result of this error, Noridian paid the provider \$5,260 when it should have paid \$188, an overpayment of \$5,072.

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. Noridian 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.⁸

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.

RECOMMENDATIONS

We recommend that Noridian:

- recover \$3,566,189 in identified overpayments,
- determine the amount of overpayment for the four incorrect line item payments and recover that amount,
- 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.

⁸ 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.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it has taken or plans to take. In our draft report, we recommended that Noridian determine and recover the overpayments associated with 26 incorrect line items that we identified. In its comments, Noridian stated that it had collected overpayments totaling \$75,119 associated with 18 of those line items. After submitting its written comments, Noridian provided additional information that showed it had collected an additional \$58,924 associated with four of the eight remaining line items. Accordingly, we have revised our findings and our first two recommendations to reflect the additional claim lines adjusted and amounts recovered. Noridian's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS



Paul O'Donnell
Vice President
Medicare Operations
900 42nd St S
Fargo, ND 58103
(701) 277-2401
FAX (701) 277-5150
paul.odonnell@noridian.com

June 27, 2011

James C. Cox
Regional Inspector General for Audit Services
Office of Inspector General
Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

RE: Report Number A-05-10-00020

Dear Mr. Cox:

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 May 26, 2011, entitled, *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Noridian Administrative Services, LLC, in Jurisdiction 6 - Minnesota for the Period of January 2006 Through June 2009*. We concur with the recommendations made by the OIG. NAS has provided our responses to these recommendations within the contents of this letter. The course of action that NAS has planned will be an ongoing effort due to the extent of activities planned and the time that can be associated with the research, development, testing and implementation of certain initiatives.

NAS researched the claims information and details provided by the OIG and has determined there are several courses of action NAS will perform to assist in reducing future overpayments. A few of the CPT/HCPC codes identified in this audit are now included on the published Medical Unlikely Edits (MUE) listing and now have unit of service limits. These MUE's are also edits in the standard Part A system, FISS, and should assist in minimizing unit of service overpayments in the future. For those codes not included in either the published or non-published MUE listings, NAS will explain our initiatives/plans to reduce future overpayments in the response below. Reviewing the list of providers included in this audit, NAS does recognize some providers are currently being educated for various reasons identified in their billings. The audit conducted by the OIG gives NAS further evidence/information of billing issues that will be reviewed and considered for recommendation to the Program Safeguard Contractor (PSC) when and if appropriate.

It's important to note that future overpayments may still be possible even after NAS has completed our plans of action due to the fact that Medicare contractors are not funded to perform 100% complex review of claims. Without a comparison of medical records and coding on 100% of claims billed, there is always going to be the potential for overpayments (and underpayments) resulting from billing incorrect procedure codes, units of service and other claims payment indicators. NAS will be diligent to avoid overpayments within the scope of our contracts, authorization and experience. An important tool or step in this process that NAS has considered is to make referrals to the Program Safeguard Contractor (PSC), Recover Audit Contractors (RAC) and CMS as a method of business collaboration.

OIG RECOMMENDATIONS:

- **Recover the \$3,432,146 in identified overpayments**

NAS Response: NAS concurs with the recommendation that all overpayments identified are to be collected.

- **Determine the amount of overpayment for the 26 incorrect line item payments and recover that amount**

NAS Response: As stated in the draft report, there were 26 claims remaining to be collected on. On Friday, 6/17/11, NAS received the detailed claims listing/findings from the OIG and has confirmed that eight of those 26 have not had adjustments submitted by the provider. Utilizing the listing provided by the OIG, NAS will contact these providers and ensure the adjustments are submitted and overpaid dollars are returned to Medicare. NAS collected \$75,119.44 on the 18 adjustments completed. Upon completion of the eight remaining adjustments, NAS will provide an update to the OIG.

- **Implement system edits that identify line item payments that exceed billed charges by a prescribed amount**

NAS Response: NAS has established an Outpatient Assessment Task Force (OATF) of seasoned Medicare staff that will be reviewing the claims data from the OIG's audit. Team Members include: Contractor Medical Director (CMD), CMD Assistant (RN), Medical Review Manager (RN) and/or Team Leader (RN), Part A Claims Manager and/or Team Leader and Part A Systems Manager and/or Team Leader and others as needed. The OATF will perform the following activities and as much as possible utilize the already established (and funded) processes and procedures within the current NAS Medicare infrastructure:

- On 5/20/11, NAS submitted a new PAR (PAR J30048) requesting FISS to establish/create a new national edit in FISS to address excessive line item payments occurring on a national basis. The PAR is currently in a *research status* as of 6/9/11. On Monday, 6/13/11, the National FISS User Group discussed this PAR and NAS will be submitting more examples for others to research and the FISS user group plans to re-visit this PAR on Monday, 6/27/11. It was stated that if this PAR is accepted it will need to be scheduled for an upcoming FISS release and that is looking to be October 2011 or later. Pending the response from FISS, if necessary, NAS will elevate this request to our CMS COTR.
- If the PAR request is not a feasible option NAS will evaluate if user controlled edits in FISS would be a viable option. NAS' preference would be to have the FISS maintainer and CMS support to implement a national system edit in FISS for consistency in processing of all Medicare claims.
- As a backup plan, the Outpatient Assessment Task Force (OATF) will be making recommendations to the Medical Review team on aberrant codes and to evaluate if the Medical Policy Parameter screen is applicable for use with the identified errors. As applicable, NAS will also make recommendations on the specific areas of vulnerabilities from the OIG audit to the applicable RAC per instructions in TDL 11148. NAS anticipates the evaluation process to begin in July 2011.
- To establish a priority ranking for implementing potential corrective actions, NAS will utilize the specific data provided on 6/17/11 for the assessment of:
 - overpayments dollars per claim (Highest to lowest)
 - units billed (Highest to lowest)
 - most frequently billed codes (Highest to lowest)
 - specific providers included in this audit (Highest claim volume to lowest)

- Perform a review of unit of services allowed and determine if a FISS User PAR should be created to submit to the data center for a standard system edit. If not possible, consider local edits as appropriate. NAS would consider returning the claim to the provider (RTP) to verify if the units billed are accurate.
 - As appropriate, the CMD will assess if a new Local Coverage Determination (LCD) is warranted or changes to any existing LCD's are needed.
 - Assess high overpayment codes in the Annual Medical Review Strategy development process (which would result in claims to be reviewed at the complex level by Medical Review Nurses)
 - Refer recommendations for post-pay reviews to the Recovery Audit Contractor (RAC) per the new CMS direction from TDL 11148 dated 2/17/11.
 - As appropriate refer recommendations to the PSC.
 - NAS' two CMD's are members of the National MUE workgroup committee and as appropriate will elevate problematic codes to the committee for review and consideration of new MUE edits.
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- **Use the results of this audit in its provider education activities**
NAS Response: NAS has several plans of action that will include various methods of provider education. The OATF will update the Provider Outreach and Education team with specific education topics as they relate to the data assessed. NAS plans the following provider education activities:
 - Develop provider training on the 'hot spots' identified through assessments.
 - Develop tools/resources on our website as a resource for providers.
 - 30 minute web ex provider education sessions (as applicable).
 - Provider education articles that will be distributed via the list-serv and posted to the NAS website.
 - Providers with an error rate of \$5,000 and above will be required to submit a corrective action plan to NAS.

Please advise if additional information or further clarification is needed on any of our response. Please contact Paul O'Donnell, Medicare Operations Vice President, at (701) 277-2401 or through email at Paul.O'Donnell@noridian.com

Sincerely,

/s/ Paul O'Donnell

Paul O'Donnell
Vice President
Noridian Administrative Services, LLC