Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PAYMENTS MADE BY NOVITAS SOLUTIONS, INC., TO HOSPITALS FOR CERTAIN ADVANCED RADIATION THERAPY SERVICES DID NOT FULLY COMPLY WITH MEDICARE REQUIREMENTS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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for Audit Services

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A-02-16-01006

Office of Inspector General

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Report in Brief
Date: November 2018
Report No. A-02-16-01006

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Payments Made by Novitas Solutions, Inc., to Hospitals for Certain Advanced Radiation Therapy Services Did Not Fully Comply With Medicare Requirements

Why OIG Did This Review

Intensity-modulated radiation therapy (IMRT) is an advanced type of radiation procedure used to treat difficult-to-reach tumors. Prior OIG reviews found that some hospitals received separate payments for individual IMRT services that should have been included in the bundled payment for IMRT planning.

During our July 2013 through December 2015 audit period, Novitas Solutions was the Medicare Administrative Contractor (MAC) responsible for processing Medicare payments for outpatient services in MAC Jurisdictions H and L.

Our objective was to determine whether selected at-risk claims for outpatient IMRT services complied with Medicare requirements.

How OIG Did This Review

Our review focused on claims paid to hospitals by Novitas that contained specific IMRT services at risk for noncompliance with Medicare requirements.

We identified 28,776 claims paid by Novitas that contained potentially unallowable IMRT services totaling $103.4 million. We selected a random sample of 100 beneficiaries and subjected the associated services to independent medical review to determine whether the claims complied with Medicare requirements. We reviewed all services associated with these claims.

What OIG Found

Novitas incorrectly paid hospitals for IMRT services provided to nearly all of the beneficiaries associated with our review. Although most of the IMRT services billed by hospitals were allowable, we determined that Novitas made overpayments for at least 1 service for 98 of the 100 beneficiaries in our random sample. Novitas appropriately made payments for the remaining two beneficiaries.

The overpayments occurred because (1) Novitas' claim processing system did not adequately prevent payments to hospitals for all incorrectly billed IMRT services and (2) hospitals were unfamiliar with or misinterpreted Medicare guidance when billing for certain IMRT services, or cited clerical errors.

Based on our sample results, we estimated that hospitals in MAC Jurisdictions H and L received Medicare overpayments of at least $7.2 million for unallowable IMRT services during our audit period.

What OIG Recommends and Novitas Comments

We made three recommendations to Novitas to recover the overpayments identified in our report. We also made two procedural recommendations to implement payment edits and to educate hospitals on properly billing for IMRT services.

In written comments on our draft report, Novitas partially agreed with one of our recommendations, concurred with our remaining recommendations, and described corrective actions it had taken or planned to take to address each of them. Specifically, Novitas stated that it would pursue overpayments for services improperly claimed for reimbursement within the reopening period; however, it would be unable to demand overpayments for certain error types because dollar estimates for each provider were not identified.

After reviewing Novitas' comments, we maintain that our findings and estimates are valid, and we encourage Novitas to take any reasonable actions, such as notifying the hospitals to review all services identified in our sampling frame and return any identified overpayments.

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INTRODUCTION

WHY WE DID THIS REVIEW

Intensity-modulated radiation therapy (IMRT) is an advanced type of radiation procedure used to treat difficult-to-reach tumors. Medicare makes a bundled payment to hospitals to cover a range of services that may be performed to develop an IMRT treatment plan. However, prior Office of Inspector General (OIG) reviews found that some hospitals received separate payments for individual IMRT services in addition to receiving the bundled payment.[1] Using computer matching, data mining, and data analysis techniques, we identified hospital claims with specific IMRT services that were at risk for noncompliance with Medicare requirements. During our audit period, Novitas Solutions, Inc. (Novitas), was the Medicare Administrative Contractor (MAC) responsible for processing Medicare fee-for-service claims for outpatient services in MAC Jurisdictions H and L, which cover 11 States and the District of Columbia.[2]

OBJECTIVE

Our objective was to determine whether selected at-risk claims for outpatient IMRT services processed for reimbursement by Novitas in MAC Jurisdictions H and L complied with Medicare requirements.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program.

CMS contracts with MACs to, among other things, process and pay Medicare claims submitted for services, conduct reviews and audits, and safeguard against fraud and abuse.

[1] This issue was identified in multiple OIG reviews of hospitals' compliance with Medicare billing requirements. In addition, OIG is currently reviewing certain IMRT services on a nation-wide basis.

[2] MAC Jurisdiction H includes Arkansas, Colorado, Louisiana, Mississippi, New Mexico, Oklahoma, and Texas. MAC Jurisdiction L includes Delaware, District of Columbia, Maryland, New Jersey, and Pennsylvania.

Hospital Outpatient Prospective Payment System and Healthcare Common Procedure Coding System Codes

Under the outpatient prospective payment system (OPPS), Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.[3] All services and items within an APC group are clinically comparable and require similar resources.

HCPCS codes are divided into two groups: level I and level II. Level I HCPCS codes consist of Current Procedural Terminology (CPT)[4] codes, a numeric coding system maintained by AMA, and are used primarily to identify medical services and procedures furnished by physicians and other health care professionals. Level II HCPCS codes are based on a standardized coding system and are used primarily to identify products, supplies, and services not included in the CPT codes. Hospitals bill radiology services, including IMRT services, using the CPT codes listed in the 70000 series of the level I HCPCS codes.

Medicare Requirements for Hospital Claims and Payments

Medicare payments may not be made for items or services that are not reasonable and necessary for diagnosing or treating illness or injury or for improving the functioning of a malformed body member (the Social Security Act (the Act) § 1862(a)(1)(A)). In addition, payments may not be made to any provider of services or other person without information necessary to determine the amount due the provider (the Act § 1833(e)). Providers must complete claims accurately so that MACs may process them correctly and promptly (CMS's *Medicare Claims Processing Manual,* Pub. No. 100-04 (the Manual), chapter 1, § 80.3.2.2).

Intensity-Modulated Radiation Therapy

IMRT is a procedure that uses advanced computer programs to plan and deliver radiation to tumors with high precision. The intensity of the radiation can be adjusted to deliver higher doses to a treatment area while reducing exposure to surrounding healthy tissue.

IMRT is provided in two treatment phases: planning and delivery. The planning phase is a multistep process in which imaging, calculations, and simulations are performed to develop an IMRT treatment plan (IMRT planning). During the delivery phase, radiation is delivered to a

[3] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

[4] **The five character codes and descriptions included in this report are obtained from Current Procedural Terminology (CPT®), copyright 2002–2013 by the American Medical Association (AMA). CPT is developed by the AMA as a listing of descriptive terms and five character identifying codes and modifiers for reporting medical services and procedures. Any use of CPT outside of this report should refer to the most current version of the Current Procedural Terminology available from AMA. Applicable FARS/DFARS apply.**

beneficiary's treatment site (i.e., a tumor) at the various intensity levels prescribed in the IMRT treatment plan.

Medicare Requirements for Intensity-Modulated Radiation Therapy

The Manual specifies the services included in the bundled payment for IMRT planning when they are performed as part of the development of an IMRT treatment plan (e.g., imaging).[5] Such services may not be billed separately, regardless of whether they are billed on the same or a different date of IMRT planning (the Manual, chapter 4, §§ 200.3.1 and 200.3.2).

National Correct Coding Initiative and Procedure-to-Procedure Claim Processing Edits

To promote correct coding by providers and to prevent Medicare payments for improperly coded services, CMS developed the National Correct Coding Initiative (NCCI).[6] MACs implemented NCCI edits within their claim processing systems for dates of service on or after January 1, 1996.

The NCCI edits include procedure-to-procedure (PTP) edits that define pairs of HCPCS codes and/or CPT codes (i.e., code pairs) that generally should not be reported together for the same beneficiary on the same date of service. For example, some edits prevent payments for certain IMRT services billed for the same beneficiary on the same date of service as a bundled payment for IMRT planning. However, these edits do not prevent payments for when these services are billed on a date different from when IMRT planning services are billed.

We maintain that this audit report constitutes credible information of potential overpayments. Providers who receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[7]

[5] Specifically, the Manual states that payment for services identified by CPT codes 77014, 77280-77295, 77305-77321, 77331, 77336, and 77370 is included in the bundled payment when they are performed as part of developing an IMRT plan that is reported using CPT code 77301. Under these circumstances, these codes should not be billed in addition to CPT code 77301.

[6] The NCCI coding policies are based on coding conventions defined in AMA's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, a review of current coding practices, and an analysis of standard medical and surgical practices.

[7] The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

HOW WE CONDUCTED THIS REVIEW

Our review focused on outpatient claims paid by Novitas in MAC Jurisdictions H and L that contained specific IMRT services at risk for noncompliance with Medicare requirements during our audit period. We reviewed claims for these IMRT services paid to hospitals by Novitas between July 1, 2013, and December 31, 2015 (audit period).[8] Specifically, we identified claims with individual IMRT services provided up to 30 days prior to the date of service for a bundled payment for the development of an IMRT treatment plan and provided to the same beneficiary by the same hospital. Generally, claims contained several line items for IMRT services.

Based on our analysis, we identified 28,776 claims that contained potentially unallowable IMRT services provided to 18,936 beneficiaries, totaling $103,425,561. We reviewed a random sample of 100 beneficiaries, which consisted of 147 claims totaling $544,729. We reviewed all services associated with these claims. We used a medical review contractor to determine whether the services were allowable in accordance with Medicare's medical necessity, documentation, and billing requirements.[9] This included reviewing medical and billing records to determine whether the services were performed as part of developing an IMRT treatment plan.

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 objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, Appendix C contains our sample results and estimates, and Appendix D contains our summary of errors for each sampled beneficiary.

FINDINGS

Novitas incorrectly paid hospitals for IMRT services provided to nearly all of the beneficiaries associated with our review. Although most of the IMRT services billed by hospitals were allowable, we determined that Novitas made overpayments for at least 1 service for 98 of the 100 beneficiaries in our random sample.[10] Novitas appropriately made payments for the remaining two beneficiaries. The following table summarizes the errors we found.

[8] This was the most current data available at the start of our review.

[9] The independent medical review contractor's staff included, but was not limited to, physicians and certified billing professionals.

[10] Multiple services were billed for each beneficiary in our sample. We only questioned the payments for unallowable services associated with the 98 beneficiaries.

Table: Summary of Errors for Sampled Beneficiaries

Error Category	No. of Beneficiaries With Overpayments[a]
Services improperly claimed for reimbursement	94
Services not supported	50
Services not medically necessary	4

[a] The total number of errors exceeds 98 because 46 sample items contained 2 types of errors, and 2 sample items contained all 3 types of errors.

The overpayments occurred because (1) Novitas' system edits did not adequately prevent payments to hospitals for all incorrectly billed IMRT services[11] and (2) hospitals were unfamiliar with or misinterpreted Medicare guidance when billing for certain IMRT services, or cited clerical errors.

Based on our sample results, we estimated that hospitals in MAC Jurisdictions H and L received Medicare overpayments of at least $7,230,420 for unallowable IMRT services during our audit period.[12]

SERVICES IMPROPERLY CLAIMED FOR REIMBURSEMENT

For 94 beneficiaries, hospitals received separate reimbursement for individual IMRT services that should have been included in the hospitals' bundled payment for the beneficiary's IMRT planning. Specifically, medical review determined that these services were provided as part of the development of an IMRT treatment plan and should not have been billed separately from the bundled payment for IMRT planning (i.e., CPT code 77301).

SERVICES NOT SUPPORTED

For 50 beneficiaries, hospitals received reimbursement for services for which the associated medical record did not support the services billed. (None of these services were provided as part of the development of an IMRT treatment plan.) Specifically:

- For 46 beneficiaries, the documentation in the medical record did not adequately support the services billed. For example, a special physics consultation was billed for a

[11] Novitas implemented NCCI edits that prevented payment to hospitals for certain IMRT services when billed on the same date of service as a bundled payment for IMRT planning. However, there were no edits in place to prevent payments when IMRT services were billed on a separate date of service prior to a bundled payment for IMRT planning.

[12] To be conservative, we estimate the total overpayments in the sampling frame at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total 95 percent of the time. At the time of issuance of this report, a portion of the estimated $7,230,420 in potential overpayments includes claims that are outside of the Medicare reopening period.

beneficiary without documentation to support the service. Specifically, medical review determined that the case file included no order for the service and no records or documentation of the service or an explanation for why the consultation was needed. In another example, a hospital billed for services that were not provided. The hospital stated that it incorrectly entered charges for IMRT because the beneficiary "was treated on a machine that is more commonly used for IMRT."

- For seven beneficiaries, the documentation did not support the number of units billed.[13]

- For one beneficiary, the hospital billed for services with an incorrect billing modifier code, resulting in an overpayment. In this instance, the hospital billed for multiple treatment devices:[14] one with a custom, complex design and two with intermediate complexity. The hospital billed with a modifier code for the two intermediate devices, which prevented NCCI PTP edits from disallowing payment when the use of these devices were not "separate and distinct" from the complex device.[15,16]

SERVICES NOT MEDICALLY NECESSARY

For four beneficiaries, hospitals received reimbursement for IMRT services that were not medically necessary. Specifically:

- For two beneficiaries, the medical record indicated that the services provided were not the appropriate standard of care. Medical review determined that three-dimensional conformal radiation therapy—not IMRT—would have been the appropriate standard of care for these beneficiaries; therefore, the claims were unallowable.[17]

- For two other beneficiaries, the medical records indicated that some services provided were not reasonable or necessary.

[13] We questioned only the excess units not supported in the beneficiaries' medical record.

[14] These treatment devices were used, in part, to immobilize the beneficiary for a simulation.

[15] One function of NCCI PTP edits is to prevent payment for codes that report overlapping services except in those instances where the services are "separate and distinct." Modifier 59 and other NCCI-associated modifiers should not be used to bypass a PTP edit unless the proper criteria for use of the modifier are met.

[16] The total exceeds 50 because 4 sample items contained 2 errors within the error category.

[17] Three-dimensional conformal radiation therapy is a cancer treatment that shapes the radiation beams to match the shape of the tumor.

RECOMMENDATIONS

We recommend that Novitas:

- recover from hospitals the portion of the estimated $7,230,420 in identified overpayments for claims incorrectly billed that are within the reopening period;[18]

- notify the hospitals responsible for the remaining portion of the estimated $7,230,420 in potential overpayments for claims that are outside of the Medicare reopening period, so that those hospitals can investigate and return any identified overpayments in accordance with the 60-day rule and track any returned overpayments;

- identify and recover any additional similar overpayments for IMRT services made after the audit period;

- work with CMS to implement edits that would prevent separate payments for individual IMRT services included in the bundled payment for IMRT planning; and

- educate hospitals on properly billing Medicare for IMRT planning services.

NOVITAS SOLUTIONS, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Novitas partially agreed with our first recommendation, agreed with our remaining recommendations, and described corrective actions it had taken or planned to take to address each of the recommendations.

Regarding our first recommendation, Novitas stated that it would pursue overpayments for services improperly claimed for reimbursement (i.e., services that should have been included in hospitals' bundled payments) within the reopening period. However, Novitas stated that it would be unable to demand overpayments for the services not supported and services not medically necessary error categories because extrapolated amounts for each provider were not identified.

[18] OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to Department of Health and Human Services action officials. Action officials at CMS, acting through a MAC or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a decision by the Office of Medicare Hearings and Appeals. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

Regarding Novitas' comments that it is unable to demand estimated overpayments associated with the unsupported and medically unnecessary services we identified, we recognize the challenges associated with recovering these amounts without knowing the extrapolated amount for each provider. However, given the systemic nature of the errors in this area, we encourage Novitas to take any reasonable actions, such as notifying the hospitals to review all services identified in our sampling frame and return any identified overpayments.

Novitas' comments are included in their entirety as Appendix E.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 28,776 claims paid by Novitas to hospitals in MAC Jurisdictions H and L that contained potentially unallowable IMRT services provided to 18,936 beneficiaries, totaling $103,425,561. Specifically, we identified beneficiaries for whom hospitals had claimed outpatient IMRT services (CPT codes 77290, 77336, 77370, 77280, 77014, or 77295) provided within 30 days prior to the date of service for the bundled payment for IMRT planning (CPT code 77301). These claims were extracted from CMS's National Claims History (NCH) file.[19]

We selected a random sample of 100 beneficiaries, with 147 associated claims totaling $544,729. We reviewed all services associated with these claims. We contracted with an independent medical review contractor that reviewed the medical records for the sampled beneficiaries' claims to determine whether services were allowable in accordance with Medicare's medical necessity, documentation, and billing requirements.

We did not assess Novitas' overall internal control structure. Rather, we limited our review of internal controls to those applicable to our audit. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data from the NCH file, but we did not assess the completeness of the file.

We conducted our fieldwork from June 2016 through December 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed Medicare officials to gain an understanding of the billing requirements for outpatient IMRT services;
- extracted paid claim data that contained outpatient IMRT services from CMS's NCH file for our audit period;
- used computer matching, data mining, and analysis techniques to identify a sampling frame of 18,936 beneficiaries with 28,776 claims totaling $103,425,561 that contained IMRT services potentially at risk for noncompliance with Medicare requirements;
- selected a simple random sample of 100 beneficiaries;

[19] We excluded claims for beneficiaries who received IMRT services from hospitals exempt from the OPPS. We also excluded claims reviewed, under review, or marked for review in the Recovery Audit Contractor data warehouse.

- obtained and reviewed hospitals' medical records and supporting documentation for services billed for the 100 sampled beneficiaries;

- requested that each hospital conduct its own review of the claims for the sampled beneficiaries to determine whether services were billed correctly;

- used an independent medical review contractor to determine whether IMRT services were allowable in accordance with Medicare medical necessity, documentation, and billing requirements;

- estimated the Medicare overpayments paid in the sampling frame; and

- discussed the results of our review with Novitas officials.

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 objectives.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

TARGET POPULATION

The population consisted of Medicare beneficiaries with paid claims for outpatient services (where claim lines with CPT codes 77290, 77336, 77370, 77280, 77014, or 77295 were provided within 30 days prior to the date of service of CPT code 77301) processed by Novitas in MAC Jurisdictions H and L during the audit period.

SAMPLING FRAME

The sampling frame consisted of 18,936 Medicare beneficiaries, with 28,776 outpatient claims that contained IMRT services totaling $103,425,561 during the audit period. These claims were processed by MAC Jurisdictions H and L, with payment dates between July 1, 2013, and December 31, 2015, and service dates on or after July 1, 2012. We matched paid claim lines with CPT codes 77290, 77336, 77370, 77280, 77014, or 77295 (first service(s)) to paid claim lines with CPT code 77301 (second service) when (1) the codes associated with the first service(s) were provided within 30 days of the second service and (2) the services were rendered to the same beneficiary by the same hospital. The claim matches were then grouped by beneficiary. As a result, one or more claims were associated with a beneficiary.

We excluded claims for beneficiaries who received IMRT services from hospitals exempt from the OPPS, including (1) hospitals located in Maryland,[20] (2) exempt cancer centers, and (3) exempt critical access hospitals. We also excluded claims reviewed, under review, or marked for review in the Recovery Audit Contractor data warehouse.

SAMPLE UNIT

The sample unit was a Medicare beneficiary.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 beneficiaries.

[20] Maryland operates under a Medicare waiver that exempts it from the Inpatient Prospective Payment System and OPPS.

SOURCE OF RANDOM NUMBERS

We generated random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the beneficiaries in the sampling frame. After generating 100 random numbers, we selected the corresponding beneficiaries in the frame for our sample.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of Medicare overpayments for unallowable outpatient IMRT services processed by Novitas at the lower limit of the two-sided 90-percent confidence interval. We also used the software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Results

No. of Beneficiaries in Sampling Frame	Value of Frame	Sample Size	Value of Sample	No. of Beneficiaries With Overpayments	Value of Overpayments in Sample
18,936	$103,425,561	100	$544,729	98	$51,807

Estimated Value of Medicare Overpayments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$9,810,215
Lower limit	7,230,420
Upper limit	12,390,010

APPENDIX D: SUMMARY OF ERRORS FOR EACH SAMPLED BENEFICIARY

Legend

Error	Description
1	Services improperly claimed for reimbursement
2	Services not supported
3	Services not medically necessary

Office of Inspector General Review for the 100 Sampled Beneficiaries

Sample Number	Error 1	Error 2	Error 3	No. of Errors
1	X	X		2
2	X	X		2
3	X			1
4	X	X		2
5	X			1
6	X			1
7	X	X		2
8	X			1
9	X	X		2
10	X			1
11	X	X		2
12	X			1
13	X	X		2
14	X			1
15	X			1
16	X	X		2
17	X	X		2
18	X	X		2
19	X			1
20	X			1
21	X	X	X	3
22	X			1
23				0
24	X	X		2
25	X			1
26	X	X		2
27	X			1
28	X	X		2

Sample Number	Error 1	Error 2	Error 3	No. of Errors
29	X	X		2
30	X	X		2
31	X			1
32	X			1
33	X	X		2
34	X			1
35	X			1
36	X	X		2
37	X	X		2
38	X	X		2
39	X			1
40	X	X		2
41				0
42	X			1
43	X			1
44	X			1
45	X			1
46	X	X		2
47	X	X		2
48	X	X		2
49	X	X		2
50	X			1
51	X	X		2
52	X	X		2
53	X	X		2
54	X	X		2
55	X			1
56	X			1
57	X	X	X	3
58	X	X		2
59	X	X		2
60	X			1
61	X	X		2
62	X	X		2
63			X	1
64	X			1
65	X	X		2
66	X			1
67	X			1

Sample Number	Error 1	Error 2	Error 3	No. of Errors
68	X			1
69	X	X		2
70	X	X		2
71	X			1
72	X	X		2
73	X			1
74	X			1
75	X	X		2
76	X			1
77	X	X		2
78	X			1
79	X			1
80		X		1
81	X	X		2
82	X			1
83	X	X		2
84	X			1
85	X	X		2
86	X	X		2
87	X			1
88	X			1
89	X			1
90	X			1
91	X	X		2
92			X	1
93	X	X		2
94	X			1
95	X			1
96	X			1
97		X		1
98	X	X		2
99	X	X		2
100	X			1
Totals	**94**	**50**	**4**	**148**

APPENDIX E: NOVITAS SOLUTIONS, INC., COMMENTS

Harvey B. Dikter
President & CEO
Novitas Solutions Inc.
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August 16, 2018

Ms. Brenda M. Tierney
Regional Inspector General for Audit Services
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Office of Audit Services, Region II
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Reference: A-02-16-01006

Dear Ms. Tierney:

Novitas Solutions, Inc. (Novitas) has received the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled, "Payments Made by Novitas Solutions, Inc., to Hospitals for Certain Advanced Radiation Therapy Services Did Not Fully Comply with Medicare Requirements" and reviewed the findings and recommendations contained herein. Novitas appreciates the opportunity to review and provide comments prior to the release of the final report.

In the draft report, the OIG outlined five recommendations that Novitas has addressed as follows:

Recommendation #1:

Recover from hospitals the estimated $7,230,420 in identified overpayments for claims incorrectly billed that is within the reopening period.

Response #1:

Novitas agrees with the finding and will pursue overpayments for services improperly claimed for reimbursement for those claims that finalized within the reopening period. For services not supported or deemed medically necessary, Novitas is

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unable to demand the estimated overpayments that are associated with these error types because specific extrapolated amounts for each provider were not identified.

Recommendation #2:

Notify the hospitals responsible for the remaining portion of the estimated $7,230,420 in potential overpayments for claims that are outside of the Medicare reopening period, so that those hospitals can investigate and return any identified overpayments in accordance with the 60-day rule and track any returned overpayments

Response #2:

Novitas will initiate notices to the providers listed in the universe of Jurisdiction L (JL) and Jurisdiction H (JH) claims received from the OIG, requesting that the providers review their internal billing protocols, conduct an internal audit, and refund all identified overpayments in accordance with CMS requirements.

Recommendation #3:

Identify and recover any additional similar overpayments for IMRT services made after the audit period

Response #3:

Novitas agrees with the finding. Novitas will identify a listing of JL and JH providers who have billed the Intensity Modulated Radiation Therapy (IMRT) planning Healthcare Common Procedure Coding System (HCPCS) codes. The identified providers will be sent a letter requesting that they review their internal billing protocols, conduct an internal audit, and refund all identified overpayments in accordance with CMS requirements.

Recommendation #4:

Work with CMS to implement edits that would prevent separate payments for individual IMRT services included in the bundled payment for IMRT planning

Response #4:

Novitas concurs with this recommendation.

CMS has implemented national edits that are designed to prevent separate payments for individual IMRT services that are included in the bundled payment for IMRT planning.

Recommendation #5:

Educate hospitals on properly billing Medicare for IMRT planning services

Response #5:

Novitas concurs with this recommendation.

Novitas has published an article reminding providers how to properly bill Medicare for IMRT planning services and update the webinar documentation that Novitas offers to the Part A provider community regarding recent changes from CMS, Novitas initiatives, and topics of interest, as well as the literature used for provider association meetings.

Again, Novitas appreciates the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding Novitas' responses, please contact Mr. Gregory W. England at 904-791-8364.

Sincerely,

Harvey B. Dikter

cc: Gregory W. England