

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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

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Office of Inspector General

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Report in Brief

Date: December 2018

Report No. A-02-16-01007

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



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, National Government Services, Inc. (NGS), was the Medicare Administrative Contractor (MAC) responsible for processing Medicare payments for outpatient services in MAC Jurisdictions 6 and K.

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 NGS that contained specific IMRT services at risk for noncompliance with Medicare requirements.

We identified 25,900 claims paid by NGS that contained potentially unallowable IMRT services totaling \$80.1 million. We selected a random sample of 100 beneficiaries and submitted the associated services for independent medical review to determine whether the claims complied with Medicare requirements. We reviewed all services associated with these claims.

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

What OIG Found

NGS 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 NGS made overpayments for at least 1 service for 99 of the 100 beneficiaries in our random sample. NGS appropriately made payments for all of the remaining beneficiary's services.

The overpayments occurred because (1) system edits did not adequately prevent payments by NGS 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 6 and K received Medicare overpayments totaling at least \$5.7 million for unallowable IMRT services during our audit period.

What OIG Recommends and NGS Comments

We made three recommendations to NGS 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, NGS took issue with our characterization of its role as a MAC with respect to our findings. Regarding our recommendations to recover overpayments, NGS indicated qualified concurrence with our first two recommendations and disagreed with our third recommendation. NGS agreed with our procedural recommendations and described corrective actions it had taken or plans to take. NGS also provided technical comments.

We revised our report language to clarify NGS's role in how Medicare claims are processed. After reviewing NGS's comments, we maintain that our findings, estimates, and recommendations are valid. We encourage NGS 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 that should have been included in the bundled payment for IMRT planning.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, National Government Services, Inc. (NGS), was the Medicare Administrative Contractor (MAC) responsible for processing Medicare fee-for-service claims for outpatient services in MAC Jurisdictions 6 and K, which cover 10 States.²

OBJECTIVE

Our objective was to determine whether selected at-risk claims for outpatient IMRT services processed for reimbursement by NGS in MAC Jurisdictions 6 and K 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.³

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 nationwide basis.

² MAC Jurisdiction 6 includes Illinois, Minnesota, and Wisconsin. MAC Jurisdiction K includes Connecticut, Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont.

³ The MACs are one of several CMS contractors who, through combined efforts, prevent and detect fraud, waste, and abuse.

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.⁴ 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)⁵ 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

⁴ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

⁵ **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).⁶ 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).⁷ 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 edits that define pairs of HCPCS codes 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.

OIG believes 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).⁸

⁶ 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.

⁷ The NCCI coding policies are based on coding conventions defined in the 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.

⁸ 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 NGS in MAC Jurisdictions 6 and K 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 NGS between July 1, 2013, and December 31, 2015 (audit period).⁹ 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 25,900 claims that contained potentially unallowable IMRT services provided to 16,199 beneficiaries, totaling \$80,113,196. We reviewed a random sample of 100 beneficiaries, which consisted of 158 claims totaling \$497,895. 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.¹⁰ 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

NGS 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 NGS made overpayments for at least 1 service for 99 of the 100 beneficiaries in our random sample.¹¹ NGS appropriately made payments for all of the remaining beneficiary's services. The following table summarizes the errors we found.

⁹ This was the most current data available at the start of our review.

¹⁰ The independent medical review contractor's staff included, but was not limited to, physicians and certified billing professionals.

¹¹ Multiple services were billed for each beneficiary in our sample. We only questioned the payments for unallowable services associated with the 99 beneficiaries.

Table: Summary of Errors for Sampled Beneficiaries

Error Category	No. of Beneficiaries With Overpayments^a
Services improperly claimed for reimbursement	95
Services not supported	46
Services not medically necessary	1

^a The total number of errors exceeded 99 because 43 sample items contained 2 types of errors.

The overpayments occurred because (1) NCCI edits did not adequately prevent payments by NGS to hospitals for all incorrectly billed IMRT services¹² 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 6 and K received Medicare overpayments of at least \$5,736,313 for unallowable IMRT services during our audit period.¹³

SERVICES IMPROPERLY CLAIMED FOR REIMBURSEMENT

For 95 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 46 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 41 beneficiaries, the documentation in the medical record did not adequately support the services billed. For example a special physics consultation was billed for a beneficiary without documentation to support the service. A special physics

¹² CMS systems included NCCI edits that prevented payment by NGS 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 because CMS had not developed these controls.

¹³ To be conservative, we report the estimated overpayment total 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 \$5,736,313 in potential overpayments includes claims that are outside of the Medicare reopening period.

consultation requires documentation showing the expertise of a qualified medical physicist; however, this was not documented in the medical record. In another example, a hospital billed for a special treatment procedure that was not provided. The hospital stated that it incorrectly entered charges for the service because of a clerical error.

- For 12 beneficiaries, the documentation did not support the number of units billed.^{14,15}

SERVICES NOT MEDICALLY NECESSARY

For one beneficiary, a hospital received reimbursement for IMRT services that were not medically necessary. (None of these services were provided as part of the development of an IMRT treatment plan.) Specifically, medical review determined that some consultation services billed for a beneficiary were excessive for a 1-day treatment.

RECOMMENDATIONS

We recommend that NGS:

- recover from hospitals the portion of the estimated \$5,736,313 in identified overpayments for claims incorrectly billed that are within the reopening period;¹⁶
- notify the hospitals responsible for the remaining portion of the estimated \$5,736,313 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;

¹⁴ We questioned only the excess units not supported in the beneficiaries' medical record.

¹⁵ The total exceeds 46 because 7 sample items contained both errors within the error category.

¹⁶ 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.

- 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.

NATIONAL GOVERNMENT SERVICES, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, NGS took issue with our characterization of its role as a MAC and requested that the report not be made publicly available. NGS indicated qualified concurrence with our first two recommendations, disagreed with our third recommendation, and agreed with our remaining recommendations and described corrective actions that it had taken or planned to take to address them. NGS also provided technical comments, which we addressed as appropriate.

We revised our report language to clarify NGS's role in how Medicare claims are processed. After reviewing NGS's comments, we maintain that our findings and recommendations are valid. NGS's comments, excluding the technical comments, appear as Appendix E.

NATIONAL GOVERNMENT SERVICES, INC.'S ROLE IN PROCESSING MEDICARE CLAIMS

National Government Services, Inc., Comments

NGS raised general concerns with several statements and conclusions in our draft report about its role with respect to the claims at issue. NGS contended that our stating that it incorrectly paid or processed claims, or did not adequately prevent payments, does not accurately reflect how Medicare claims are processed and paid, and NGS set forth the roles various Medicare contractors have in the process. NGS also stated that we inaccurately attributed responsibility for implementing and maintaining NCCI edits to MACs. NGS also stated that our report should not be posted publicly in light of its concerns.

In its comments on our third recommendation, NGS stated that it is the responsibility of other CMS contractors to identify and recover overpayments for IMRT services made after our audit period, and NGS does not have the contractual obligation, authority, or resources to review every IMRT claim. In its comments on our fourth and fifth recommendations, NGS stated, respectively, that it would work with CMS and other contractors to address IMRT payment issues, through edits, for Medicare-related billing systems, and work with CMS to provide outreach and education materials to providers.

Office of Inspector General Response

We acknowledge that MACs are not solely responsible for identifying and preventing overpayments. Further, we agree with NGS's statement that MACs do not implement or maintain NCCI edits, and revised our report to clarify that CMS bears ultimate responsibility for

NCCI system edits. Nevertheless, CMS contracts with MACs to process and pay Medicare claims submitted for services and conduct reviews and audits and we maintain that it is accurate to state that NGS incorrectly paid certain claims, regardless of whether NGS was at fault. Specifically, we determined that NCCI edits did not adequately prevent NGS from making overpayments because they only prevented payments when certain IMRT services were billed on the same date of service as a bundled payment for IMRT planning, among other causes. Accordingly, we recommended that NGS work with CMS to implement edits to correct this (Recommendation 4), and NGS agreed.

We maintain that our third recommendation is valid and that NGS should identify and recover overpayments made after our audit period that were similar to those identified in our report. Although other CMS contractors have a role in safeguarding claims from fraud and abuse, CMS's *Medicare Program Integrity Manual* (the PIM), Pub. No. 100-08, states that MACs "shall focus their edits where the services billed have significant potential to be non-covered or incorrectly coded The MACs have the discretion to select target areas because of . . . OIG . . . data demonstrating vulnerability."¹⁷ Our findings clearly describe a vulnerability in how some providers bill for certain IMRT services.

The PIM also states that "the MACs . . . have the discretion to select cases for postpayment review on a claim-by-claim basis or use statistical sampling for overpayment estimation."¹⁸ Further, as described in NGS's contract with CMS, NGS is "required to perform collection activities for all overpayments, including overpayments resulting from OIG audits, and make the necessary recoveries within a reasonable timeframe. . . ."¹⁹

We also disagree with NGS's contention that publishing this report in final is prohibited by law.

SAMPLING METHODOLOGY

National Government Services, Inc., Comments

Although NGS did not dispute our findings, in its comments on our first recommendation, it recommended that our sample claims be referred to a CMS contractor (known as a Uniform Program Integrity Contractor) to confirm our sample size and estimated overpayment. NGS stated that it would then work with the contractor to implement our first and second recommendations.

¹⁷ Chapter 3, § 3.2.1 of the PIM.

¹⁸ Chapter 3, § 3.5.2 of the PIM.

¹⁹ Part A and Part B Medicare Administrative Contractor Statement of Work Jurisdiction K, Attachment J-01, section C.5.11.5. Available online at <https://www.fbo.gov/index.php?s=opportunity&mode=form&id=4b96039d1e4ee48166271704ebe4647b&tab=documents&tabmode=list&subtab=list&subtabmode=list&=>. Accessed on October 31, 2018.

Office of Inspector General Response

We report the estimated overpayment at the lower limit of a two-sided 90-percent confidence interval. This approach is conservative, regardless of the size of the sample relative to the sampling frame. Because of the large number of providers in the sampling frame, we are not recommending that NGS use the estimated overpayment total directly in a redetermination letter. Rather, the estimate is intended to highlight the amount that is potentially recoverable if NGS takes action on the identified high-risk claims in our sampling frame. For example, NGS could pursue overpayments for services improperly claimed for reimbursement for claims that were finalized within the reopening period. Also, NGS could send notices to the providers in our sampling frame requesting that they review their internal billing protocols, conduct an internal audit, and refund all identified overpayments in accordance with CMS requirements.

We provided a summary of our medical review contractor's conclusions to NGS and can provide additional information to assist in its recovery efforts.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered 25,900 claims paid by NGS to hospitals in MAC Jurisdictions 6 and K that contained potentially unallowable IMRT services provided to 16,199 beneficiaries, totaling \$80,113,196. 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.²⁰

We selected a random sample of 100 beneficiaries with 158 associated claims totaling \$497,895. 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 NGS's 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 January 2018.

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 16,199 beneficiaries with 25,900 claims totaling \$80,113,196 that contained IMRT services potentially at risk for noncompliance with Medicare requirements;
- selected a simple random sample of 100 beneficiaries;

²⁰ We excluded claims for beneficiaries who received IMRT services from hospitals exempt from the OPPI. 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 NGS 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 NGS in MAC Jurisdictions 6 and K during the audit period.

SAMPLING FRAME

The sampling frame consisted of 16,199 Medicare beneficiaries, with 25,900 outpatient claims that contained IMRT services totaling \$80,113,196 during the audit period. These claims were processed by MAC Jurisdictions 6 and K, 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 OPSS: exempt cancer centers and 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.

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 NGS 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
16,199	\$80,113,196	100	\$497,895	99	\$41,413

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

Point estimate	\$6,708,515
Lower limit	5,736,313
Upper limit	7,680,717

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			1
3	X			1
4	X	X		2
5		X		1
6	X			1
7	X			1
8	X			1
9	X			1
10	X	X		2
11	X			1
12	X			1
13	X	X		2
14	X			1
15	X	X		2
16	X	X		2
17	X	X		2
18	X			1
19				0
20	X			1
21	X			1
22	X			1
23	X			1
24	X	X		2
25	X			1
26	X			1
27	X	X		2
28	X			1

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

Sample Number	Error 1	Error 2	Error 3	No. of Errors
68	X	X		2
69	X	X		2
70	X	X		2
71	X	X		2
72	X			1
73	X			1
74	X			1
75	X			1
76	X			1
77	X			1
78	X	X		2
79	X		X	2
80		X		1
81		X		1
82	X			1
83	X			1
84	X	X		2
85	X			1
86	X	X		2
87	X	X		2
88	X			1
89	X			1
90	X	X		2
91	X			1
92	X			1
93	X			1
94	X	X		2
95	X	X		2
96	X			1
97	X			1
98	X			1
99		X		1
100	X	X		2
Totals	95	46	1	142

APPENDIX E: NATIONAL GOVERNMENT SERVICES, INC., COMMENTS



MEDICARE

8115 Knue Road|INA102-AF-25
Indianapolis, IN 46250

September 06, 2018

Ms. Brenda M. Tierney
Regional Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: **Draft Report Number A-02-16-01007 - Payments Made by National Government Services, Inc., to Hospitals for Certain Advanced Radiation Therapy Services Did Not Fully Comply With Medicare Requirements.**

Dear Ms. Tierney:

Thank you for the opportunity to review and comment on the above-referenced report (Draft Report). As a Medicare Administrative Contractor (MAC), we absolutely are committed to working with the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) to reduce any improper payments to providers. Our responses to your office's specific findings are set forth in Section 3, below. Before that, however, we write to raise some general concerns regarding a number of statements and conclusions in the report, as well as your intent to post this report publicly.

I. The Draft Report Mischaracterizes NGS' Role With Respect to the Claims at Issue

First, in several places, the Draft Report indicates that "NGS incorrectly paid" or processed claims that resulted in overpayments and that these overpayments occurred, in part, because "NGS' claim processing system did not adequately prevent payments for all incorrectly billed IMRT services."¹ As demonstrated below, that conclusion does not accurately reflect how Medicare claims are processed and paid.

First and foremost, the Medicare program is structured to rely on providers to bill appropriately. All electronic Medicare Part A and B claims are processed on CMS "shared systems"—the Fiscal Intermediary Standard System (FISS) for Part A and the Multi-Carrier System (MCS) for Part B—that interact with the Common Working File (CWF).² Internet Only Manual (IOM) Pub 100-01, General Information, Eligibility, and Entitlement Manual, Chapter 7, Section 40.3. These shared systems are maintained by different contractors, called "Maintainers." IOM Pub 100-1, Chapter 7, Section 40.3.9. The vast majority of Medicare claims are

¹ IMRT is Intensity-Modulated Radiation Therapy.

² The CWF comprises nine localized databases ("Hosts") that contain and maintain the claim history and entitlement information for every Medicare beneficiary. All claims are processed against this file; it is updated daily. See IOM <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104e27.pdf>.





adjudicated by these systems without any MAC review.³ In that regard, the shared systems edits needed to address the IMRT payment issue would need to be worked through the MACs, CMS, and the Maintainers jointly. Accordingly, to the extent providers may have received an overpayment on these IMRT claims, it is an unfair characterization to conclude these overpayments occurred because NGS paid these claims incorrectly.

Moreover, Medicare claim volumes are so high that individual review of every claim for compliance with every requirement of the Medicare program is impossible. See IOM Pub 100-08, Medicare Program Integrity Manual, Chapter 3, Section 3.2.1. MACs are instructed to target their efforts at error prevention to those areas that pose the greatest financial risk to the Medicare program. *Id.* MACs also are required to articulate these efforts in their Medical Review strategy and Strategy Analysis Report – which are reviewed and approved by CMS. *Id.* The fact that a specific category of claim was not identified for Medical Review is not, in and of itself, a basis to conclude that a MAC did not meet its contractual obligations.

Second, the Draft Report also notes, in the background section (on page 1), that CMS contracts with MACs to, among other things, “safeguard against fraud and abuse.” We concur, as a MAC, NGS certainly *assists to* safeguard against fraud and abuse. It is important to note this is a combined effort among several CMS contractors, including UPICs⁴, RACs,⁵ SMRCs,⁶ and CERTs,⁷ that perform a majority of the fraud and abuse work as they are best situated to implement the claim identification and recovery efforts recommended in the Draft Report.

Finally, the Draft Report (on page 5) also seems to inaccurately place responsibility for National Correct Coding Initiative (NCCI) edits on MACs. MACs neither code nor implement the NCCI edits. That responsibility also lies with the Maintainers. See IOM Pub 100-01, General Information, Eligibility, and Entitlement Manual, Chapter 7, Section 40.

As the foregoing demonstrates, the Draft Report inaccurately describes the claims adjudication process under the Medicare program and can be read to unjustly question NGS’s competence and integrity as a MAC. We note that your office issued a markedly similar report (A-09-16-02033) to CMS earlier this month. That report is more accurate in so far as it does not conflate the roles of the various Medicare contractors, and does

³ In point of fact, these claims are not initially processed by MACs, but by the CMS Virtual Data Center contractors.

⁴ Unified Program Integrity Contractors (formerly called Zone Program Integrity Contractors (ZPICs) and Program Safeguard Contractors (PSCs)) are responsible for preventing, detecting, and deterring fraud, waste, and abuse in both the Medicare program and the Medicaid program. Pub 100-08, Program Integrity Manual, Chapter 4 §4.2.1.

⁵ Recovery Audit Contractors (also called Recovery Auditors (RAs)). RACs are charged with reviewing claims on a post-payment basis. 42 U.S.C. § 1395ddd(b); 42 C.F.R. § 421.304.

⁶ “The Supplemental Medical Review Contractor’s (SMRC) main tasks are to perform and/or provide support for a variety of tasks aimed at lowering the improper payment rates and increasing efficiencies of the medical review functions of the Medicare and Medicaid programs. Having a centralized medical review (MR) resource that can perform large volume MR nationally allows for a timely and consistent execution of MR review, activities and decisions. The focus of the reviews may include but are not limited to issues identified by CMS internal data analysis, the CERT program, professional organizations and other Federal agencies, such as the OIG/GAO and comparative billing reports.” Pub 100-08, Program Integrity Manual, Chapter 1, §1.3.1D.

⁷ Comprehensive Error Rate Testing (CERT) contractors establish payment error rates and estimates of improper payments. Pub 100-08, Program Integrity Manual, Chapter 1, §1.3.1D.

not wrongly fault MACs for the issues identified. Our suggested revisions in Exhibit 1 reflect this more accurate depiction of the issue and its potential fix

II. The Report Should Not Be Posted Publicly

The Inspector General Reform Act of 2008 (the “Act”) does not require that the OIG publish all audits. Section 8M of the Act requires only the posting of “publicly available” reports or audits, without prescribing which types of reports or audits, or what phase of an audit or report, must be “made publicly available.”⁸ And, of course, the Act does not provide independent grounds for publicizing the Audit that would supersede the Freedom of Information Act (“FOIA”)⁹ rules of what records are properly releasable.¹⁰ In light of the concerns we raised above, it would be inappropriate for the OIG to publish the report in its current form. If the OIG does not adopt our recommended revisions, then NGS hereby objects to its unredacted release for the reasons noted in Section I.

Additionally, FOIA Exemption 5 protects the deliberative processes of agencies and exempts the subject report from disclosure.¹¹ Exemption 5 expressly protects “deliberative process” communications from release, in order to protect the quality of agency decisions.¹² This exemption should apply here.

The deliberative process exemption applies to communications that are pre-decisional¹³ and deliberative.¹⁴ This report satisfies both elements. As demonstrated above, both the body and recommendations of the draft report conflate the roles and responsibilities of the various contractors that CMS utilizes to administer the Medicare program. It also does not appear to include any concurrence from the agency itself, which ultimately would be tasked with implementing the recommendations. Because the report does not yet appropriately reflect the correct facts or a final agency decision, it should be withheld from release in its entirety. There is certainly no requirement to post the report publicly at this stage.

⁸ 5 U.S.C. § APP 3 § 8M.

⁹ 5 U.S.C. § 552.

¹⁰ Indeed, the Act makes clear that nothing within the Act shall be construed to authorize the public disclosure of information specifically prohibited from disclosure by any other provision of law. 5 U.S.C. § APP 3 § 5(e)(1).

¹¹ 5 U.S.C. § 552(b)(5).

¹² Under Exemption 5, a decision within an agency decision making process may be protectable if the release of that information would have the effect of prematurely disclosing the recommended outcome of the consultative process as well as the source of any decision. The purpose of this exemption is to “prevent injury to the quality of agency decisions.” *Wolfe v. HHS*, 839 F.2d 768, 775 (D.C. Cir. 1988); see also *NLRB v. Sears, Roebuck & Co.*, 421 U.S. 132, 151 (1975); *Nat’l Ass’n of Criminal Def. Lawyers v. United States Dep’t of Justice*, No. 97-372, slip op. at 7-8 (D.D.C. July 22, 1998) (protecting agency-generated draft report circulated to nongovernmental parties for review and comment).

¹³ *Jordan v. United States Dep’t of Justice*, 591 F.2d 753, 772-73 (D.C. Cir. 1978) (en banc).

¹⁴ See *Mapother v. Dep’t of Justice*, 3 F.3d 1533, 1537 (D.C. Cir. 1993) (“a direct part of the deliberative process in that it makes recommendations”); citing *Petroleum Info. Corp. v. United States Dep’t of the Interior*, 976 F.2d 1429, 1434 (D.C. Cir. 1992) (stating that “[t]he deliberative process privilege protects materials that are both predecisional and deliberative”).

III. NGS Responses to the Draft Report's Recommendations:

- **Recommendation 1. Recover from hospitals the estimated \$5,736,313 in identified overpayments for claims incorrectly billed that are within the reopening period;**

NGS Response: The OIG identified a potential universe of 29,500 claims and calculated an extrapolated overpayment based on a review of 100 (0.33%) claims. NGS recommends that these claims be referred to the Uniform Program Integrity Contractor (UPIC) for confirmation of the sample size and overpayment. NGS would then process any overpayment determination in accordance with our contract, our Joint Operating Agreement with the UPIC, and the applicable regulations.

- **Recommendation 2. Notify the hospitals responsible for the remaining portion of the estimated \$5,736,313 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;**

NGS Response: NGS is willing to work with the UPIC to implement this recommendation.

- **Recommendation 3. Identify and recover any additional similar overpayments for IMRT services made after the audit period;**

NGS Response: NGS respectfully submits that this is the responsibility of the cognizant RAC, UPIC, or SMRC. NGS has neither the contractual obligation, authority, nor resources to review every IMRT submitted. Additionally, NGS does not have the ability to identify every claim that was improperly unbundled, nor would any MAC be able to do so.

- **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;**

NGS Response: We note that these changes already appear to have been implemented by the Maintainers via CR 10229. To the extent this remains an issue, NGS will work with CMS and the Maintainers to explore the implementation of additional shared system editing.

- **Recommendation 5. Educate hospitals on properly billing Medicare for IMRT planning services.**

NGS Response: NGS concurs with this recommendation and will work with CMS to address this issue through provider outreach and education materials.

Ms. Brenda M. Tierney
September 6, 2018
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Thank you, again, for the opportunity to review and comment. We are, of course, happy to discuss any and all aspects of this response further.

Respectfully submitted,

/s/ Robert M. Squier, Jr.

Robert M. Squier, Jr.
Associate General Counsel
National Government Services, Inc.