Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION OVERPAID A PROVIDER THAT INCORRECTLY BILLED FOR AFLIBERCEPT

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

Patricia Wheeler
Regional Inspector General
for Audit Services

June 2015
A-06-14-00051

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

INTRODUCTION

Wisconsin Physicians Service Insurance Corporation overpaid $431,692 to a provider that incorrectly billed for aflibercept.

WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) pays Medicare claims through a Medicare administrative contractor (Medicare contractor) in each Medicare jurisdiction. Previous Office of Inspector General reviews have identified Medicare payments for outpatient drugs as vulnerable to incorrect coding.

OBJECTIVE

Our objective was to determine whether certain payments that the Medicare contractor for Jurisdiction 5, Wisconsin Physicians Service Insurance Corporation (WPS), made to a provider for aflibercept were correct.

BACKGROUND

Medicare Part B

Part B of Medicare provides supplementary medical insurance, including limited coverage for the cost of outpatient drugs and biologicals that are furnished incident to a physician's service and are not usually self-administered.[1] CMS administers Part B and contracts with Medicare contractors to, among other things, determine reimbursement amounts and pay claims, conduct reviews and audits, and safeguard against fraud and abuse. Medicare contractors must establish and maintain efficient and effective internal controls.[2]

Healthcare Common Procedure Coding System Codes

Medicare contractors pay providers using established rates for each hospital outpatient unit of service claimed, subject to any Part B deductible and coinsurance. Each submitted claim may contain multiple line items that detail most provided services. Providers must use standardized codes, called Healthcare Common Procedure Coding System (HCPCS) codes, for drugs administered and report units of service in multiples of the units shown in the HCPCS narrative description. For example, if the description for the HCPCS code specifies 50 milligrams (mg) and 200 mg are administered, units are shown as four on the claim.

Wisconsin Physicians Service Insurance Corporation

During most of our audit period (July 1, 2012, through September 30, 2013), WPS was the

[1] CMS *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 50.

[2] CMS *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, section 10.1.2.

Medicare contractor for Jurisdiction 5 (Iowa, Kansas, Missouri, and Nebraska). Effective October 22, 2012, WPS became the Medicare contractor for Jurisdiction 5. WPS processed and paid all the line items we reviewed.

Aflibercept and Ziv-Aflibercept

Aflibercept is a drug used for the treatment of patients with age-related macular degeneration. Beginning July 2012, providers billed Medicare using HCPCS code Q2046 and then changed to J0178 effective January 2013. During our audit period, Medicare reimbursement was $980.50 per 1 mg of aflibercept administered.[3] The manufacturer recommended dose is 2 mg.

Ziv-aflibercept is a drug used in combination with other chemotherapy drugs to treat metastatic colorectal cancer. In August 2012, ziv-aflibercept became eligible for Medicare reimbursement but did not have an assigned HCPCS code. Beginning in January 2013, providers billed Medicare using HCPCS code C9296. During our audit period, Medicare reimbursement ranged from $15.57 to $11.10 per 1 mg administered.[4] The manufacturer recommended dose is 4 mg per 2.2 pounds of body weight; thus, 400 mg would be the recommended dose for a 220-pound person.

HOW WE CONDUCTED THIS REVIEW

During our audit period, WPS paid $2,800,676 in hospital outpatient services for 1,318 line items for aflibercept. We reviewed three line items, billed by one provider, with total payments of $437,794 for aflibercept (HCPCS codes Q2046 or J0178) paid by WPS with diagnosis codes other than macular degeneration and with unit counts that exceeded the recommended dose. We did not review entire claims; rather, we reviewed specific line items within the claims.

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.

FINDING

Payments that WPS made to a provider for aflibercept for all three line items we reviewed were not correct. For all three line items, the provider billed an incorrect HCPCS code. The provider attributed the incorrect billings to confusion caused by similar drug names. In addition to relying on the provider to confirm that the line items were billed correctly, WPS performed its own

[3] Medicare Part B Drug Average Sales Price files maintained by CMS. Available online at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html. Accessed on March 16, 2015.

[4] *Ibid.*

research and incorrectly concluded that the HCPCS code billed by the provider was correct. As a result, WPS paid the provider a total of $437,794; it should have paid $6,102, an overpayment of $431,692.

FEDERAL REQUIREMENTS

The Social Security Act (the Act) and CMS Pub. No. 100-04, *Medicare Claims Processing Manual* (the Manual), provide overall requirements related to the billing and payment of hospital outpatient services. They require that providers submit accurate and complete bills to Medicare for allowable and covered services and identify the number of units of service for each outpatient drug administered to a Medicare beneficiary using the correct HCPCS code.[5]

The Manual states that Medicare contractors must "edit for outpatient and inpatient Part B claims that meet or exceed a reimbursement amount of $50,000" (chapter 1, section 140.1). The section further notes that Medicare contractors must "suspend those claims receiving the threshold edit for development and contact providers to resolve billing errors." If a Medicare contractor determines that the reimbursement is excessive and corrections are required, the claim must be returned to the provider. If the billing is accurate and the reimbursement is not excessive, the Medicare contractor will override the edit and process the claim for payment.

INCORRECT HEALTHCARE COMMON PROCEDURE CODING SYSTEM CODE

The provider billed the three line items using an incorrect HCPCS code. For all three line items, the provider administered ziv-aflibercept but billed for aflibercept. The provider attributed the incorrect billing to confusion caused by the two drugs' similar names. WPS suspended the three line items when they were initially submitted but paid the line items after the provider and WPS's own research confirmed that the line items were billed correctly. As a result, WPS paid the provider a total of $437,794 when it should have paid $6,102, an overpayment of $431,692.

RECOMMENDATION

We recommend that WPS recover the $431,692 in identified overpayments.

WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION COMMENTS

In written comments on our draft report, WPS stated that it had recovered the identified overpayments, including interest. WPS's comments are included in their entirety as Appendix B.

[5] The Act, section 1833(e), and the Manual, chapter 17, section 90.2.A.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

For the period July 1, 2012, through September 30, 2013, we limited our review to determining whether the HCPCS codes submitted on a selected outpatient claim that resulted in a high-dollar Medicare payment for aflibercept was supported by the provider's medical record documentation. We did not review the entire claim; rather, we reviewed specific line items within the claim.

We limited our review of the provider'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.

We conducted our audit work from August 2014 through April 2015 by contacting the Medicare contractor in Wisconsin, and the provider, in Missouri.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws and guidance;
- analyzed CMS's National Claims History file to identify high-dollar outpatient claims for aflibercept potentially at risk for noncompliance with selected Medicare billing requirements;
- reviewed available data for the selected claim to determine whether the claim had been cancelled or adjusted;
- identified three line items totaling $437,794 for aflibercept (HCPCS codes Q2046 or J0178) paid by the Medicare contractor and having diagnosis codes other than the one used for macular degeneration and unit counts that exceeded the recommended dose;
- contacted the provider to determine whether the HCPCS codes for the selected line items were correct and, if not, why the HCPCS codes were incorrect;
- requested that the provider review the patient medical records, specifically the physician orders and drug administration records, to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with the Medicare contractor; and
- discussed the results of our review with Medicare contractor 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: WISCONSIN PHYSICIAN SERVICE INSURANCE CORPORATION COMMENTS

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare

May 29, 2015

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

RE: Office of Inspector General (OIG) Draft Report – A-06-14-00051

Dear Ms. Wheeler,

This letter is in response to the OIG draft report titled *Wisconsin Physicians Service Insurance Corporation Overpaid a Provider That Incorrectly Billed for Aflibercept*.

OIG reviewed three line items, billed by one provider, with total payments of $437,794 for aflibercept (HCPCS codes Q2046 OR J0178) paid by WPS with diagnosis codes other than macular degeneration and with unit counts that exceeded the recommended dose.

The OIG report stated: *Payments that WPS made to a provider for aflibercept for all three line items we reviewed were not correct. For all three line items, the provider billed an incorrect HCPCS code. The provider attributed the incorrect billings to confusion caused by similar drug names. In addition to relying on the provider to confirm that the line items were billed correctly, WPS performed its own research and incorrectly concluded that the HCPCS code billed by the provider was correct. As a result, WPS paid the provider a total of $437,794; it should have paid $6,102, an overpayment of $431,692.*

OIG Recommendations to WPS:

- *recover the $431,692 in identified overpayments,*

WPS Response to the OIG Recommendations:

- WPS has recovered $435,426.23 in identified overpayments including $3,733.76 in interest which is a full recovery of the identified overpayments.

If you have any questions or need additional information, please contact me at 402-995-0443.

Sincerely,

Mark DeFoil
Director, Contract Coordination

* Office of Inspector General Note - The names of the persons sent a duplicate copy (cc) of the comments have been redacted from WPS's comments because a name is personally identifiable information.

WPS HEALTH INSURANCE

Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare Contractor
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