Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

Medicare Payments for the Same Service by More Than One Carrier

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OEI-03-00-00090

OFFICE OF INSPECTOR GENERAL

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EXECUTIVE SUMMARY

PURPOSE

To determine if multiple carriers paid for duplicate Part B services rendered by the same provider.

BACKGROUND

The Health Care Financing Administration (HCFA) contracts with private health insurance companies called carriers to process Part B claims for reimbursement. After furnishing a physician service, providers submit a claim for reimbursement to the carrier with jurisdiction over this service. Under the Common Working File system, the carrier then sends the claims information to one of nine host sites for approval. At the host site, the claim is screened for consistency, entitlement, and duplication of previously processed claims.

Potentially duplicate claims are ones which contain identical elements for a service. Both the carriers and the Common Working File host sites are required to review incoming claims for possible duplication using certain criteria, and to deny ones that are potentially duplicate.

For this inspection, we selected a sample of potential duplicate services from HCFA's 5 percent National Claims History file for 1998. We contacted carriers who had paid for the services in our sample, and asked them to identify the providers who had billed for these services. We then asked providers to furnish us with medical documentation to support the sample services. Sample services represented 15 different procedure codes. We also examined data from HCFA's 100 percent claims file for the providers who rendered services in our sample.

FINDINGS

Medicare's claims processing system did not prevent any of the duplicate payments in our sample

None of the medical records received from providers in our sample justified billings to multiple carriers. Although carriers and Common Working File host sites have checks designed to detect duplicate billings, these measures are clearly vulnerable to duplicate claims that are sent to different carriers.

Some sample providers had a significant number of potential duplicate billings

In reviewing 100 percent of the providers' billings for the 15 procedure codes reviewed, we found that nearly one-fourth of the providers in our sample (20 of 86) had at least 20 services involving potential duplicate billings. Seven providers had more than 100 services involving potential duplicate billings in 1998. Further, the duplicate billings were not limited to the 15 codes. We found other duplicate billings representing additional services, including evaluation and management services, group psychotherapy, and magnetic resonance imaging.

RECOMMENDATIONS

We believe our findings highlight a significant vulnerability in Medicare's claims processing system. The inability to detect duplicate payments by multiple carriers could lead to substantial future losses for Medicare.

To address the vulnerabilities identified in this report, we recommend that HCFA:

Revise Common Working File edits to detect and deny duplicate billings to more than one carrier. If this measure is determined not to be cost effective, then increased post-payment reviews should be conducted, particularly in areas where providers commonly perform services in multiple carrier jurisdictions.

Promote provider compliance and cooperation with the Office of Inspector General's *Compliance Program Guidance for Individual and Small Group Physician Practices.* Providers in solo or small group physician offices should be encouraged to conduct effective voluntary compliance activities to maintain optimum levels of integrity in their practices.

Encourage providers to clarify carrier jurisdiction questions, in addition to other billing questions, by using toll-free telephone lines recently established by carriers.

We have forwarded claims information to HCFA so they may take appropriate action regarding the duplicate payments cited in this report. In addition, we have referred some of the providers that we identified as having high numbers of duplicate billings to our Office of Investigations.

AGENCY COMMENTS

The HCFA concurred with our recommendations. The HCFA stated that they will reexamine existing criteria regarding duplicate editing in the Common Working File system to determine the cost effectiveness of including the carrier number in the match

criteria. If a revision is determined not to be cost effective, improved duplicate billing edits will be considered within the Common Working File redesign initiative. The HCFA also plans to prepare a model article for inclusion in all Medicare contractor carrier bulletins, reminding providers to conduct effective voluntary compliance activities to ensure high levels of integrity in their practices. To encourage providers to clarify carrier jurisdiction questions via the carrier toll-free telephone lines, HCFA will instruct carriers to alert personnel servicing the toll-free lines to be sensitive to this issue and to provide appropriate information to providers.

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INTRODUCTION

PURPOSE

To determine if multiple carriers paid for duplicate Part B services rendered by the same provider. [1]

BACKGROUND

The Health Care Financing Administration (HCFA), which administers the Medicare program, contracts with private health insurance companies called carriers to process Part B claims for payment. Claims under Medicare Part B include medical and surgical services by physicians, ambulance services, durable medical equipment, outpatient hospital services, and laboratory services.

Carrier Jurisdiction

After physician services are furnished to a Medicare beneficiary, the provider submits a claim for reimbursement to the carrier with jurisdiction over the service. In accordance with the Omnibus Reconciliation Act of 1989, as amended by the Omnibus Reconciliation Act of 1990, carrier jurisdiction for physician services was revised to reflect the locality where the service was furnished. Previously, carrier jurisdiction was based on the location of the physician's office. The rule governing carrier jurisdiction has been in effect since January 1, 1992; however, carriers were allowed to delay its implementation until July 1, 1998.

Processing Part B Claims

A carrier receives claims via electronic submission or mail. The carrier enters the claim into its processing system, calculates the payment amount, and conducts consistency and utilization checks using computerized edits. The carrier then sends the claim to one of nine host sites of the Common Working File (CWF) system. The HCFA established the Common Working File system in 1991 to improve the accuracy of claims processing. The host sites maintain beneficiary claims history and entitlement information. Each beneficiary is assigned to only one host site. At the host site, the claim is screened for consistency, entitlement, and duplication of previously processed claims. This screening process is Medicare's front line of defense against paying inappropriate claims. Within

[1] The term "provider," as used in this report, refers to any practitioner who provides a Part B service to a Medicare beneficiary.

24 hours of receiving a claim, the host site makes one of three payment determinations: (1) pay the claim, (2) reject the claim, or (3) hold the claim to obtain missing information.

Detecting Duplicate Payments

As part of Medicare's guidelines to detect and prevent inappropriate payments, both the Common Working File system and the carriers are required to conduct checks on claims to detect duplicate payments. The Common Working File host sites check for exact duplicate claims by comparing the carrier number, the claim's document control number, and service dates on the File's history record. If these fields are identical on two claims, one claim is denied. According to procedures described in the Medicare Carriers Manual regarding the control of potentially duplicate payments, as well as information obtained from HCFA, carriers are required to deny claims that match on certain fields (beneficiary's health insurance claim number, identical service dates, provider number, type of service, procedure code, place of service, and submitted charge). As a further check for duplicate services, service dates are matched with one or more of the following variables: provider number, type of service, and procedure code. If these items match, the claim is held for review and duplicate payments are denied. Line items within claims are also compared for duplicate entries.

METHODOLOGY

To determine if multiple carriers appropriately paid for what appeared to be duplicate services, we obtained and reviewed medical documentation from a sample of providers to see if it justified the services.

Sampling

We examined 1998 Part B paid services for a 5 percent sample of Medicare beneficiaries in the National Claims History file. This 5 percent file, which contained adjustments through June 1999, was 98 percent complete. We used six criteria to determine if two services appeared to be duplicate: the beneficiary's health insurance claim number; the Unique Physician Identification Number of the provider performing the service; the start date of service; HCFA's Common Procedure Coding System code describing the service; and the two modifiers that can further describe the service. If the six criteria for two services were identical, we considered those services to be potential duplicates. From this pool of potentially duplicate services, we selected those that had been billed to more than one carrier. As a result of this effort, we identified a universe of 5,876 services.

From the 5,876 services, we identified 40 procedure codes with the highest allowed payment amounts in 1998. With the assistance of a carrier's medical staff, we arrayed the codes into three categories: (1) services that should only be billed once per day by a single provider, (2) services that should rarely be billed more than once per day, and (3) services which could commonly be billed more than once per day. We narrowed our sample of procedure codes to include 15 from the first two categories. In our selection, we attempted to include a wide variety of service codes representing diverse provider specialties in various places of service. We then selected a random sample of services from each of the 15 codes.

We divided the 15 codes into three tiers based on number of potential duplicate services. The first tier had 14 or fewer duplicate services. The second tier had 16-34, and the third tier had more than 34 services. For more information, see Appendix A. From each procedure code in the first tier, we chose a maximum of eight services. From each code in the second and third tiers, we selected a maximum of 14 and 30 services respectively. At this stage of sample selection, we had a total of 250 services conducted by 89 providers. We subsequently eliminated services from three providers who were either under investigation by the Inspector General's Office of Investigations (six services), or whose Unique Physician Identification Number was not accurately reflected on the National Claims History file (two services). Our resulting sample included 242 total services by 86 different providers. Pending receipt of documentation from providers, we presumed these 242 services actually represented 121 legitimate services which had been appropriately billed to the correct carrier, and 121 duplicate services which somehow had been billed to, and paid by, an additional carrier.

Data Collection

Carrier requests. We contacted each carrier that had paid for a service in our sample. We requested that carriers identify the names and addresses, including both the location and billing address, of the providers who submitted claims for our sample services. As each duplicate service in our sample was billed to multiple carriers, we typically requested each provider's name and address information from two carriers. In response, we often received two different addresses for each provider. In addition, we asked carriers to confirm the Unique Physician Identification Number of the providers identified in the National Claims History file as having rendered the services. We also asked the carriers for copies of the claims that contained our sample services.

Provider requests. We contacted providers using two methods: by mail or through an on-site visit.

Our primary method of contacting providers was via letters, asking them to furnish us with medical documentation to support the services in our sample. We sent a form with each letter which detailed key elements of each service, including the name of the carrier that was billed.

As mentioned above, we often had two addresses for each provider, one from each carrier. If the two carriers gave us the same address, we sent two forms, each representing one service, to that address. If the two carriers provided us with different addresses, we sent a separate form to each address. Primarily, we mailed the letters to the location addresses provided by the carriers. In the absence of a location address, we used billing addresses. We sent 121 letters to 82 providers, and visited 4 providers to obtain the medical documentation in person.

If a provider returned two forms along with medical documentation, we considered the response complete. However, if the provider returned only one form for one carrier along with documentation, we contacted the provider to determine if a different set of records was available for the service billed to the other carrier. We telephoned providers if they failed to respond by the due dates contained in the letters.

Several providers did not submit documentation even after repeated follow-up telephone calls. In these instances, we sent the provider a letter stating we would conclude the provider did not have the documentation if we didn't receive it by a certain date. We did not hear back from five providers. Therefore, we counted them as not having documentation.

When making follow-up contacts for medical documentation, we were careful to point out that two carriers had paid for the billed services, and that the provider should send us documentation to support each service billed. We also asked providers or their office personnel to explain why duplicate billings had been submitted to more than one carrier.

Of the 86 providers in our sample, 79 sent medical documentation, representing 222 services. Five providers, representing 12 services, did not send any medical documentation. Two providers, representing 8 services, could not be located. Consequently, there were 234 services for which we received or attempted to obtain documentation.

Additional data provided by HCFA. As stated above, our sample of 242 total services involving 86 providers was pulled from a 5 percent sample of Medicare beneficiaries in the National Claims History file. In order to learn more about their billing practices, we asked HCFA to provide us with data for our sample providers from the 100 percent claims file. This file contains claims information for all Medicare beneficiaries. Furthermore, this file was more current than the 5 percent claims file, as it included any adjustments in services made through June 2000.

Data Analysis

Medical documentation from providers. We reviewed medical documentation from providers to determine if the services should have been billed to two carriers. We did not review the documentation to determine medical necessity. We determined that the

potential duplicate billing would be justified if there were medical documentation to support each service billed. For example, in the case of an inpatient hospital visit, the medical documentation sent to us should have verified, at a minimum, medical care by the same provider for the same patient on the same day in two hospitals located in different carrier jurisdictions. If documentation supported one service only, we determined that one of the claims was a duplicate, and should not have been paid.

We computed overpayment amounts for the services in our sample. If documentation was submitted to support only one billing, we attributed the correct payment to the carrier where the service was rendered. If we were unable to ascertain which carrier had jurisdiction for the service performed based on the medical records sent to us, we attributed the correct payment to the carrier with the higher allowed amount (thereby, resulting in a lower and more conservative improper payment amount). If the allowed amounts were the same, we attributed payment to the carrier listed first in our database.

Provider billing histories. We examined the 100 percent National Claims History file for Part B paid services for all beneficiaries seen by the providers in our sample. We identified all Part B services billed by our sample providers in 1998. Using six criteria (described on page 2), we identified the total number of potential duplicate services billed by sample providers. We analyzed duplicate billings for the 15 procedure codes in our sample, as well as all other procedure codes. We also calculated the allowed amounts for these services.

As the 100 percent National Claims History file contained more current data than the 5 percent file, we analyzed it to determine if any adjustments to our sample services had been made. We found that 16 services in our sample were eliminated from the more current data in the 100 percent claims file. The dropped services may signify that the carrier, provider, or other party discovered the duplicate billing and the provider refunded the overpayment to Medicare. These services, representing seven providers, were retained in our sample since we obtained the 100 percent claims file after collecting medical documentation from providers.

This study was conducted in accordance with the *Quality Standards for Inspections* issued by the President's Council on Integrity and Efficiency.

FINDINGS

Medicare's claims processing system did not prevent any of the duplicate payments in our sample

None of the medical records received from providers in our sample justified billings to multiple carriers. For 222 services, provider documentation did not support the need for billing two separate carriers. Therefore, half of these services (111) were improperly submitted to and paid by a Medicare carrier. There were an additional 12 services for which no documentation was provided. Medicare allowances for the 123 improper services totaled almost $12,000. We estimate total improper allowances for the 15 codes as approximately $446,000. See Appendix B for estimate and confidence interval.

Although carriers and Common Working File host sites have checks designed to detect duplicate billings, these measures are clearly vulnerable to duplicate claims sent to different carriers. Carrier edits are designed to detect duplicates within a carrier, rather than across carriers. Carriers, therefore, cannot compare their incoming claims with those received by neighboring carriers. The only time that duplicate claims submitted to multiple carriers could be identified is when the data is sent to the host sites for processing. For the services in our sample, however, it appears that the Common Working File system did not identify duplicate services billed to more than one carrier.

Few providers reported making refunds to Medicare

Only eight providers stated that they had refunded overpayments to the appropriate carrier. Seven of these providers initiated the refunds as a result of our inquiries. These refunds totaled approximately $1,100 and included not only the services in our sample, but other duplicate payments which the provider discovered following our inquiries. An additional four providers, who acknowledged their errors, asked for instructions on how they should refund their excessive payments to the appropriate carrier.

Providers gave various reasons to explain duplicate billings

Fifteen providers told us that, prior to our requests, they were totally ignorant of the existence of the duplicate billings and had no idea how they had occurred. Another seven providers cited the policy change, which based carrier jurisdiction on where the service was performed rather than the location of the provider's office, as the reason for their duplicate billings. Although this policy was effective in 1992, carriers were allowed to delay implementation until July 1998. One New York City provider explained in a letter, "I learned from a billing seminar . . . that claims for patient services received in Queens . . . are processed by GHI [Group Health Incorporated]. After

learning this, I reapplied for reimbursement to GHI . . . and assumed that I would not be paid by Empire. However . . . both Empire and GHI sent reimbursements to my office." Other explanations cited by providers included confusion caused by carrier transitions, having offices or performing services across State lines, and inadvertent errors by billing services.

Some sample providers had a significant number of potential duplicate billings

In reviewing 100 percent of the providers' billings for the 15 procedure codes, we found that nearly one-fourth of the sample providers (20 of 86) had at least 20 services involving potential duplicate billings to multiple carriers. One of the 20 providers had 966 potential duplicate services, with questionable allowances totaling about $31,000. Another six of the 20 providers had at least 100 services involving potential duplicate billings. The 86 sample providers had a total of 2,871 services representing approximately $101,000 in improper allowances due to questionable billings to multiple carriers.

For some sample providers, potential duplicate services comprised a high percentage of overall services for the 15 codes reviewed. As shown in Table 1, potential duplicate services represented one-fifth or more of the total services paid by Medicare to several providers. Specifically, there were 5 providers whose potential duplicate services represented 20 percent or more of their overall billings. For 8 of the 86 providers, at least 10 percent of their total 1998 Medicare billings involved potential duplicate services. In contrast, for more than two-thirds of the 86 providers, potential duplicate billings represented less than 1 percent of their total Medicare claims.

Table 1. Percentage of Services Involving Potential Duplicates for 15 Sample Codes

Provider	Number of services involving duplication	Total number of services overall	Percentage of services involving duplication
A	334	828	40%
B	966	2748	35%
C	114	332	34%
D	38	124	31%
E	115	565	20%

A detailed review of all procedure codes showed that duplicate billings to multiple carriers were not limited to the 15 codes in our sample. For the 86 providers, an additional 1,667 services involved potential duplicate billings, representing nearly $86,000 in improper allowances. Fourteen of the top 25 codes that appeared most frequently were evaluation and management codes used for physician services. Many of these codes can be billed only once per day, and, therefore, any duplication would seem questionable. Other procedure codes involved in the duplicate billings were group

psychotherapy (90853), subsequent nursing facility care per day (99312), end stage renal disease related services per day (90925), and spinal canal magnetic resonance imaging (72148). The definitions for these codes suggest that a provider would rarely furnish a beneficiary with two of these services on the same day, especially in two different carrier jurisdictions.

RECOMMENDATIONS

We believe our findings highlight a significant vulnerability in Medicare's claims processing system. The inability to detect duplicate payments by multiple carriers could lead to substantial future losses for Medicare.

To address the vulnerabilities identified in this report, we recommend that HCFA:

Revise Common Working File edits to detect and deny duplicate billings to more than one carrier. If this measure is determined not to be cost effective, then increased post-payment reviews should be conducted, particularly in areas where providers commonly perform services in multiple carrier jurisdictions.

Promote provider compliance and cooperation with the Office of Inspector General's *Compliance Program Guidance for Individual and Small Group Physician Practices.* Providers in solo or small group physician offices should be encouraged to conduct effective voluntary compliance activities to maintain optimum levels of integrity in their practices.

Encourage providers to clarify carrier jurisdiction questions, in addition to other billing questions, by using toll-free telephone lines recently established by carriers.

We have forwarded claims information to HCFA so they may take appropriate action regarding the duplicate payments cited in this report. In addition, we have referred some of the providers that we identified as having high numbers of duplicate billings to our Office of Investigations.

AGENCY COMMENTS

The HCFA concurred with our recommendations. The HCFA stated that they will reexamine existing criteria regarding duplicate editing in the Common Working File system to determine the cost effectiveness of including the carrier number in the match criteria. If a revision is determined not to be cost effective, improved duplicate billing edits will be considered within the Common Working File redesign initiative. The HCFA also plans to prepare a model article for inclusion in all Medicare contractor carrier bulletins, reminding providers to conduct effective voluntary compliance activities to ensure high levels of integrity in their practices. To encourage providers to clarify carrier jurisdiction questions via the carrier toll-free telephone lines, HCFA will instruct carriers to alert personnel servicing the toll-free lines to be sensitive to this issue and to provide appropriate information to providers.

APPENDIX A

Procedure Codes Included in Sample

	Procedure Code	Number of Potential Duplicate Services in Universe	Number of Services Selected for Sample
Tier 1	70553	2	2
	72158	4	4
	90921	8	8
	66984	12	8
	90801	14	8
Tier 2	99223	16	14
	99204	20	14
	99254	20	14
	99244	24	14
	11721	34	14
Tier 3	90862	42	30
	99238*	42	24
	90816	82	30
	99232*	110	28
	99213	226	30
	TOTAL	**656**	**242**

*Six services from procedure code 99238 were dropped from the sample, as the provider was under investigation by the Inspector General's Office of Investigations. Two services were dropped from procedure code 99232, as the provider's Unique Physician Identification Number was not accurately reflected on the National Claims History file.

APPENDIX B

Estimate and Confidence Interval

We used the Survey Data Analysis (SUDAAN) software package to compute allowance and confidence interval estimates presented in the following table. The estimate is weighted based on the sample design and is reported at the 95 percent confidence level.

	Weighted Total Estimate	95% Confidence Interval
Questionable Medicare Allowances for 15 Sample Codes	$446,015	$367,775 - $524,255

APPENDIX C

Health Care Financing Administration Comments

APPENDIX C

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: FEB 16 2001

TO: Michael F. Mangano
Acting Inspector General

FROM: Michael McMullan
Acting Deputy Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Medicare Payments for the Same Service by More Than One Carrier," (OEI-03-00-00090)

We appreciate the opportunity to comment on the issues raised in the above-referenced report.

We have been aggressive in our efforts to make sure that we pay Medicare claims correctly. Medicare has also reduced its improper payment rate sharply from 14 percent four years ago to less than 8 percent last year, and the Health Care Financing Administration (HCFA) is committed to achieving further reductions in the future.

When providers bill for services that aren't allowed, they're taking Medicare funds that should be used to provide needed care for seniors and disabled Americans.

The OIG found that Medicare's claim processing systems did not prevent duplicate payments by more than one carrier for any of the sample services. The OIG estimates that the total improper allowances for these services, represented by 15 procedure codes, to be approximately $446,000. In its review of all of the providers' billings for the sample services, OIG reports that some providers had significant numbers of potential duplicate billings.

Our specific comments are as follows:

OIG Recommendation
Revise Common Working File (CWF) edits to detect and deny duplicate billings to more than one carrier.

HCFA Response
We concur. HCFA will reexamine existing criteria for duplicate editing in CWF. Originally, these checks were primarily to guard against duplicated electronic transmissions rather than to detect duplicate billings. HCFA will assess the impact on run-time, cost, and contractor resources of CWF edits that do not include a carrier number in the match criteria. Findings from the assessment will be used to determine the cost effectiveness of this approach. If altering CWF edits is not deemed cost effective in

the current environment, improved duplicate billing edits will be considered within the CWF redesign initiative. Additionally, we will consider developing a task order for a Program Safeguard Contractor to develop measures to address this vulnerability.

OIG Recommendation
Promote provider concurrence and cooperation with the OIG's *Compliance Program Guidance for Individual and Small Group Physician Practices*.

HCFA Response
We concur. We will prepare a model article to be included in all Medicare contractor carrier bulletins, reminding providers about the OIG Compliance Program Guidance and encouraging them to conduct effective voluntary compliance activities to maintain optimum levels of integrity in their practices.

OIG Recommendation
Encourage providers to clarify carrier jurisdiction questions, in addition to other billing questions, by using toll-free telephone lines recently established by carriers.

HCFA Response
We concur. As part of a Program Instruction, transmitting the model article mentioned above, we also will instruct Medicare carriers to alert their professional relations staffs and staffs servicing the toll-free telephone lines to be sensitive to this issue and to provide appropriate information to providers.