



DEPARTMENT OF HEALTH & HUMAN SERVICES

---

Office Of Inspector General  
Office of Audit Services

Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza  
New York, NY 10278  
November 17, 2003

Report Number: A-02-02-01038

Mr. Thomas E. Poccia  
Vice President and Chief Financial Officer  
Lenox Hill Hospital  
100 East 77<sup>th</sup> Street  
New York, New York 10021

Dear Mr. Poccia:

Attached is a copy of our final report providing the results of our self-initiated "Review of Medicare Secondary Payer Processes at Lenox Hill Hospital for Claims Paid between July 1, 2001 and March 31, 2002". A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

The objectives of the audit were to assess the effects on the Medicare program of Lenox Hill Hospital's (Lenox) processes and controls with respect to the Medicare Secondary Payer (MSP) provision. Specifically, the audit evaluated the processes, procedures and controls for identifying your patients' insurers and filing health insurance claims. We also examined the related MSP accounting functions for recording accounts receivable and cash receipts and for tracking and recording credit balances.

Medicare laws, regulations and guidelines specify the conditions under which parties other than the Medicare program have the primary responsibility to pay for health care services rendered to Medicare beneficiaries. These laws, regulations and guidelines specify the responsibilities of the beneficiary, the Centers for Medicare & Medicaid Services (CMS), the Medicare providers and the Medicare contractor with respect to the MSP provisions.

The results of our review indicate that Lenox's MSP processes, procedures and controls were generally adequate and resulted in proper determinations, but that Lenox did not always identify the appropriate primary payer; as a result, the Medicare program was overcharged on behalf of three of the 40 beneficiaries in our review in the amount of \$10,691. We also determined that Lenox underreported its credit balances (i.e., excess payments resulting from billing or claims processing errors) to CMS in the amount of \$13,066.

We are recommending that Lenox:

Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information,

Improve the patient information in the computerized registration so that current and accurate MSP information is readily available to those who need it,

Ensure that the Medicare program is reimbursed \$10,691 for the improper payments identified in this audit,

- Ensure that pending adjustments, such as the credit balance of \$13,066 identified through this audit, are included in its CMS-838, and

Place greater emphasis on the importance of CMS-838 reporting requirements through a tightening of relevant policies and controls.

In written comments, Lenox concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. Lenox also noted that it has implemented tighter internal controls to assure compliance with MSP requirements.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, OAS reports issued to the Department's grantees and contractors are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Report Number A-02-02-01014 in all correspondence. Any questions or further comments on any aspect of the report are welcome. Please address them to me at (212) 264-4620 or through e-mail at [thorgan@oig.hhs.gov](mailto:thorgan@oig.hhs.gov).

Sincerely,

  
Timothy J. Horgan  
Regional Inspector General  
for Audit Services

Attachment

**Direct Reply to HHS Action Official:**

Mr. James T. Kerr, Regional Administrator  
Centers for Medicare & Medicaid Services  
26 Federal Plaza, Room 3811  
New York, New York 10278

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE SECONDARY  
PAYER PROCESSES AT LENOX HILL  
HOSPITAL**



**Inspector General**

**NOVEMBER 2003**

**A-02-02-01038**

# *Office of Inspector General*

<http://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## *Office of Audit Services*

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

## *Office of Evaluation and Inspections*

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

## *Office of Investigations*

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees state Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## *Office of Counsel to the Inspector General*

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.



Office of Audit Services  
Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza, Room 3900A  
New York, NY 10278

November 17, 2003

Our Reference: Report No. A-02-02-01038

Mr. Thomas E. Poccia  
Vice President and Chief Financial Officer  
Lenox Hill Hospital  
100 East 77<sup>th</sup> Street  
New York, New York 10021

Dear Mr. Poccia:

This report provides the results of our "REVIEW OF MEDICARE SECONDARY PAYER PROCESSES AT LENOX HILL HOSPITAL FOR CLAIMS PAID BETWEEN JULY, 1 2001 AND MARCH 31, 2002".

The objectives of the review were to assess the effects on the Medicare program of Lenox Hill Hospital's (Lenox) processes and controls with respect to the Medicare Secondary Payer (MSP) provision. Specifically, the audit evaluated Lenox's processes, procedures and controls for identifying its patients' insurers and filing health insurance claims. We also examined the related MSP accounting functions for recording accounts receivable and cash receipts and for tracking and recording credit balances.

The results of our audit indicate that Lenox's MSP processes, procedures and controls were generally adequate and resulted in proper determinations, but that Lenox did not always identify the appropriate primary payer; as a result, the Medicare program was overcharged on behalf of three of the 40 beneficiaries in our review in the amount of \$10,691. We also determined that Lenox underreported its credit balances (*i.e.*, excess payments resulting from billing or claims processing errors) to the Centers for Medicare & Medicaid Services (CMS) in the amount of \$13,066.

We, therefore, recommend that Lenox:

- ❑ Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information,
- ❑ Improve the patient information in the computerized registration system so that current and accurate MSP information is readily available to those who need it,

- ❑ Ensure that the Medicare program is reimbursed \$10,691 for the improper payments identified in this audit,
- ❑ Ensure that pending adjustments, such as the credit balance of \$13,066 identified through this audit, are included in its CMS-838, and
- ❑ Place greater emphasis on the importance of CMS-838 reporting requirements through a tightening of relevant policies and procedures.

Lenox concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. Lenox also noted that it has implemented tighter internal controls to assure compliance with MSP requirements. The full text of Lenox's response is attached as an appendix to this report.

## INTRODUCTION

### BACKGROUND

The Social Security Amendments of 1965 established the Medicare program under Title XVIII of the Social Security Act (Act). Section 1862(b) [42 U.S.C. 1395y] of the Act established the Medicare Secondary Payer (MSP) provisions and the conditions under which the Medicare program does not have the primary financial responsibility for health care services rendered to Medicare beneficiaries.

Specifically, Medicare is the secondary payer for:

- ❑ The Working Aged - beneficiaries age 65 or over, or their spouses, who are covered under employer group health plans (EGHP);
- ❑ The Disabled – beneficiaries under age 65 who are covered by a Large Employer Group Health Plan (LGHP), and
- ❑ Individuals with End-Stage Renal Disease – beneficiaries covered by an EGHP during the first 30 months of Medicare entitlement based on end-stage renal disease (ESRD).

In addition, Medicare may be the secondary payer for any beneficiary for:

- ❑ Claims involving No-Fault or Liability Insurance, or
- ❑ Claims involving other Government Programs, such as a State or Federal workers' compensation program or the Department of Veterans Affairs.

A secondary payment is coordinated with the primary payment such that Medicare will generally pay the difference between the amount charged and the amount of a primary payment, subject to certain limits. Under certain circumstances, however, the provider is obligated to accept a primary payment as payment in full, in which case no residual payment is due from Medicare. Finally, any improper primary Medicare payments must be repaid within 60 days of a notice or other information indicating that the MSP provisions apply.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

The audit objectives were to assess the effects on the Medicare program of hospital processes and controls with respect to the MSP provision. Specifically, the audit evaluated processes used to identify the patient's insurers, file claims, record accounts receivable and cash receipts, and track and record credit balances.

### **Scope**

The audit population included claims paid between July 1, 2001 and March 31, 2002 with the following characteristics:

- Cost Avoidances - these claims were included because the population included paid claims for a beneficiary for whom other claims were denied because of prepayment MSP edits;
- MSP Adjustment Claims – these claims were included in the population because the provider re-filed the claim to indicate a change in the beneficiary's MSP status;
- Other MSP Claims – these claims were processed for primary payment by Medicare but were included in the population to determine if other claim indicators suggested that only secondary benefits were due;
- Non-Group Health Plan Claims – these claims were processed for secondary Medicare payments, but the primary payer was not an EGHP or LGHP; they were selected because of the possibility that the secondary Medicare payment was improper, and
- No Pay Claims – the provider filed these claims to indicate that another payer was responsible for payment. These items were included in the population to determine whether Medicare should have paid any other claims for the same beneficiary.

### **Methodology**

To accomplish the objectives, we:

- Reviewed applicable laws, regulations and guidelines;
- Reviewed the hospital's MSP procedures, processes and controls;
- Selected, through non-statistical means, all claims meeting the parameters described in the Scope section of this report for 40 beneficiaries;
- Obtained and reviewed, for each claim for each of the 40 beneficiaries:
  - Medicare claims,
  - Common Working File (CWF) data,
  - MSP Questionnaires,
  - Information in the Hospital Admission and Discharge Records,
  - Explanations of Benefits from other insurers, and
  - Information in the Hospital Financial System, Accounts Receivable and Cash Receipts Records, and
- Obtained and reviewed the Credit Balance Reports for each quarter in the audit period.

Fieldwork was performed at Empire Medicare Services (Empire), the Medicare contractor that processes Lenox's claims, in Syracuse, New York, at Lenox Hill Hospital, New York, NY and our New York City Field Offices between August 2002 and June 2003. The audit was performed in accordance with generally accepted government auditing standards.

## FINDINGS AND RECOMMENDATIONS

### CRITERIA

Medicare laws, regulations and guidelines specify the conditions under which parties other than the Medicare program have the primary responsibility to pay for health care services rendered to Medicare beneficiaries. As noted above, Medicare is generally the secondary payer for three categories of beneficiaries (the working aged, the disabled and beneficiaries with ESRD). In addition, parties other than Medicare (e.g., automobile no fault insurance, liability insurance or workers compensation programs) may have the primary obligation to pay claims resulting from accidents involving any Medicare beneficiary.

These laws, regulations and guidelines also specify the responsibilities of the beneficiary, the Centers for Medicare & Medicaid Services (CMS), the Medicare providers and the Medicare contractor with respect to the MSP provisions.

Further details about the MSP laws, regulations and guidelines are included in Appendix A

### Review of MSP Processes, Procedures and Controls

To evaluate the adequacy of Lenox's MSP processes, procedures, and controls, we conducted interviews with Lenox officials and reviewed items such as:

- flowcharts outlining the MSP roles and responsibilities at Lenox;
- written policies and procedures addressing patient registration and admission, and
- the billing, accounts receivable, and cash receipts processes for MSP claims.

We found that Lenox's MSP processes, procedures and controls were generally adequate. However, we also noted that the written procedures on MSP questionnaires, as updated in October 2002, were not always current, e.g.,

- a. The written policies were apparently updated in October 2002 to incorporate changes in MSP processes that were published in the Hospital Manual in April 2002.
- b. The updated policies referred to an 18-month period during which Medicare is secondary to EGHP coverage for ESRD patients; however, the Balanced Budget Act of 1997 extended this waiting period from 18 months to 30 months.
- c. The updated policies required an MSP questionnaire for every encounter, despite CMS program memoranda in September 2001 and March 2002 indicating that questionnaires are only required once every 90 days for certain outpatient services.

Lenox officials informed us that they intend to update their written MSP procedures to address these concerns.

### **Identifying MSP Coverage**

The identification of MSP coverage under Medicare laws, regulations and guidelines involves the beneficiary, CMS, Medicare providers such as Lenox and Medicare contractors such as Empire. For example, when beneficiaries enroll for Medicare, CMS requests information about other primary coverage. Using this and other information, CMS updates the Common Working File to record the beneficiaries' MSP information.

Hospitals are required to consider the CWF data before billing Medicare and are generally also required to obtain specific information about all other insurance coverage before filing Medicare claims. Under most circumstances, hospitals must record the patient's responses to the requested information on an MSP questionnaire. For "hospital reference lab" services (*i.e.*, laboratory services on behalf of beneficiaries who are not hospital patients) and "recurring outpatient services" (*i.e.*, identical services rendered on an outpatient basis more than once within a billing cycle), however, information obtained within the last 90 days may be accepted without further development. CMS requires that providers retain copies of the MSP questionnaires for 10 years.

Medicare contractors, such as Empire, are generally advised to accept assertions of Medicare primary payer responsibility as shown on the Medicare claim and are expected to update the CWF file as new information is received from a hospital or a beneficiary.

To evaluate the adequacy of Lenox's MSP questionnaires for the 40 beneficiaries in our sample, we first considered whether the questionnaires provided complete answers about other insurance coverage, as required by Chapter II of CMS's Hospital Manual. We found that questionnaires for six (15 percent) of the 40 sampled beneficiaries were incomplete and lacked critical MSP information. We also evaluated Lenox's MSP processes by determining whether Lenox noted and resolved inconsistent answers either within a questionnaire or among different questionnaires for an individual beneficiary. Through these means, we determined that six (15 percent) of the 40 beneficiaries' questionnaires contained material inconsistencies (*e.g.*, contradictory bases for Medicare eligibility [disability, age, or ESRD] or improper identification of a private insurer) that could impact on MSP determinations. In total, questionnaires for nine (22.5 percent) of the 40 beneficiaries were incomplete or inconsistent (questionnaires for three beneficiaries were both incomplete and inconsistent).

Our review of the 137 Medicare claims (paid at \$683,092 during the audit period) for the 40 beneficiaries indicated that Lenox generally processed MSP claims correctly despite the incomplete or inconsistent answers to the MSP questionnaires. We therefore believe that Lenox's reliance on other sources of MSP information (*e.g.*, Explanations of Benefits from other insurers and notes and records in Lenox's financial system) generally resulted in proper MSP determinations. We note, however, that better MSP questionnaires might have reduced payment delays resulting from instances when Lenox had to re-file or re-develop claims (for example, by contacting the beneficiary or the beneficiary's other insurers) before Medicare or other insurers would authorize payment. To a lesser extent, the audit also identified six claims for three beneficiaries that were improperly paid \$10,691 by Medicare, at least in part because of incomplete or inconsistent MSP questionnaires, as illustrated by the following examples.

- A beneficiary had received treatment for an accident covered by no-fault insurance. Since none of the MSP questionnaires for the beneficiary's subsequent claims reported a no-fault situation, Empire paid primary Medicare benefits. Nearly two years later, our audit detected the inconsistency between the MSP information for the first claim and the subsequent claims. As a result, Lenox has determined that the no-fault insurer is liable for all of these claims.
  
- Two MSP questionnaires for a disabled beneficiary, when compared to each other, indicated that the beneficiary's spouse had health insurance coverage through a LGHP. Lenox officials, however, failed to consider the spouse's LGHP in coordinating benefits. Based on our audit, Lenox officials realized that the spouse's LGHP, rather than the Medicare program, should have paid primary benefits.

Lenox officials have indicated that they agree with our findings concerning these improper payments and plan to take corrective action.

## **CAUSE**

These improper Medicare payments resulted from weaknesses in the gathering of MSP information in the admission and registration processes as well as the failure to resolve contradictory MSP information on a timely basis.

It should be noted that, in addition to retaining a consulting firm in 1998 to improve its MSP processes, Lenox officials initiated a review of its MSP processes in March 2003 as a result of discussions relating to our audit.

### **Review of the Medicare Credit Balance Report**

A credit balance is the result of an improper or excess payment (e.g., duplicate payments from Medicare and another insurer) because of billing or claims processing errors. When such situations occur, the Paperwork Burden Reduction Act of 1980 and §§1815(a), 1833(e) and 1866(a)(1)(C) of the Social Security Act require providers to refund incorrect payments and to submit a Medicare Credit Balance Report (Form CMS-838) to the Medicare contractor within 30 days after the close of each calendar quarter.

We found that Lenox had not submitted Form CMS-838 to report a credit balance totaling \$13,066 for one of the 40 beneficiaries in our sample. Specifically, a payment from a private insurer in the quarter ended June 2002 resulted in a credit balance that was not reported on Form CMS-838 although a timely adjustment claim was filed to report the Medicare overpayment.

Lenox agreed that the claim should have been reported on its CMS-838 in the appropriate period and indicated a need to tighten policies and procedures relating to CMS-838 reporting requirements.

## **CAUSE**

The unreported credit balances are primarily a consequence of clerical errors.

## **RECOMMENDATIONS**

In general, we found that Lenox's MSP processes were adequate and resulted in proper MSP determinations and properly filed Medicare Credit Balance Reports. The audit, however, identified certain errors that indicate opportunities to improve the implementation of MSP policies at Lenox.

We, therefore, recommend that Lenox:

- ❑ Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information,
- ❑ Improve the patient information in the computerized registration system so that current and accurate MSP information is readily available to those who need it,
- ❑ Ensure that the Medicare program is reimbursed \$10,691 for the improper payments identified in this audit,
- ❑ Ensure that pending adjustments, such as the credit balance of \$13,066 identified through this audit, are included in its CMS-838, and
- ❑ Place greater emphasis on the importance of CMS-838 reporting requirements through a tightening of relevant policies and procedures.

### **Lenox Hill Hospital's Response**

Lenox, in its response dated October 30, 2003, concurred with the recommendations and noted that corrective actions have already been taken with respect to the reported findings. Lenox also noted that it has implemented tighter internal controls to assure compliance with MSP requirements. The full text of Lenox's response is attached as an appendix to this report.

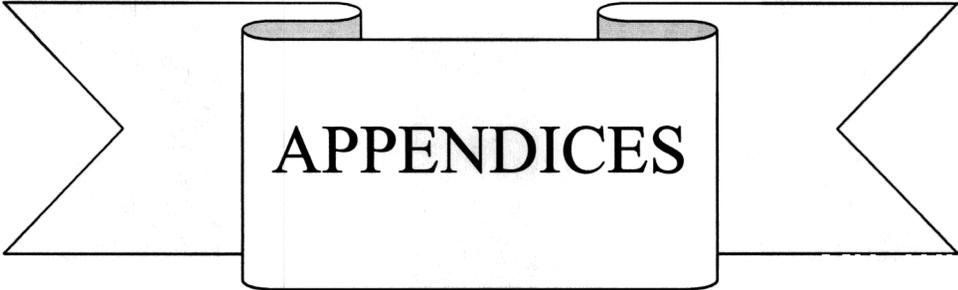
**Office of Audit Services' Comments**

We are pleased to note that Lenox has initiated corrective actions and reviews of its procedures to address the recommendations.

Sincerely,



Timothy J. Horgan  
Regional Inspector General  
for Audit Services



### **Summary of Key Guidelines related to the MSP Program**

The Social Security Act § 1862(b) sets forth the laws for the Medicare as Secondary Payer program. The basic provisions of the MSP laws were established and amended over time through the following legislation:

- The Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) provides that Medicare is a secondary payer when an employee (or employee's spouse) age 65 through 69 is covered by an employer group health plan (EGHP) effective January 1, 1983. These provisions apply only to those employers with at least 20 employees.
- The Deficit Reduction Act of 1984 (P.L. 98-369) broadened the definition of a "working spouse" effective January 1, 1985 to include all spouses (regardless of age) covered by an EGHP.
- The Consolidated Omnibus Reconciliation Act of 1985 (P.L. 98-272) expanded the definition of "working aged" effective January 1, 1986 to include employees over the age of 69.
- The Omnibus Reconciliation Act of 1986 (OBRA) (P.L. 99-509) expanded the MSP provisions effective January 1, 1987 to include disabled employees and their working spouses who are covered by a "large" EGHP, which is defined as a plan offered by an employer with at least 100 employees.
- The OBRA of 1987 (P.L. 100-203) clarified the OBRA of 1986 provisions to indicate that government entities are primary payers for disabled employees covered by Medicare.
- The OBRA of 1989 (P.L. 101-239) established penalties for primary payers who fail to honor their obligations to provide for primary payments. It also clarified that secondary Medicare payments are limited to an amount not to exceed amounts payable if Medicare were primary; the limit applies to both the Medicare payment itself and the total payments from both the primary payer and Medicare.
- The OBRA of 1990 (P.L. 101-508) modified MSP provisions for Medicare beneficiaries with end-stage renal disease (ESRD) by instituting an 18-month period after the start of dialysis during which Medicare is secondary. The provision applied solely to services rendered between 1991 and 1995.
- The OBRA of 1993 (P.L. 103-66) extended the provisions of OBRA of 1990 such that Medicare is secondary for the first 18 months of ESRD entitlement for services rendered through September 30, 1998.
- The Balanced Budget Act of 1997 (BBA) (P.L. 105-33) instituted a 30-month period after the start of dialysis during which Medicare is secondary. It also extended the time period

during which the United States may seek recovery of conditional Medicare payments from liable primary payers to three years from the date when the service was rendered. Finally, the BBA clarified that beneficiaries are generally not liable for MSP overpayments unless Medicare issued payment directly to the beneficiary.

Additional guidelines about the MSP provisions were included in the following CMS publications:

- CMS Hospital Manual, Chapter II §§ 262-264.17 and 289-289.24; Chapter III, §§ 300-301.3 and 308 to 309 and Chapter IV, § 468-484.7
- CMS Medicare Intermediary Manual, Part III, Chapter VI, § 3506-3521.4 and Chapter VII, § 3682-3697.3
- CMS Program Memoranda:
  - A-92-5 – June 8, 1992 “Reinstatement of Mandatory Credit Balance Reporting Requirements”
  - AB-01-18 – February 1, 2001 “New Automatic Notice of Change to Medicare Secondary Payer (MSP) Auxiliary File”
  - A-01-116 - September 25, 2001 - “Medicare Secondary Payer (MSP) Policies Relaxed for Hospitals”
  - AB-02-011 – February 1, 2002 “Notice of Interest Rate for Medicare Overpayments and Underpayments” and
  - A-02-021 - March 22, 2002 - “Medicare Secondary Payer (MSP) Information Collection Policies Changed for Hospitals”

The following “Intermediary Bulletins” from Empire Medicare Services, the Medicare contractor for Lenox, also contained guidance related to the MSP provisions:

- Empire Medicare Services News Bulletin – March 1998 “Medicare as Secondary Payer”
- Empire Medicare Services News Update – September 2000 “Credit Balance Reporting Instructions – Changes Effective October 1, 2000”

**Lenox Hill Hospital**

100 East 77th Street  
New York, New York 10021-1883

**Administration**



October 30, 2003

Mr. Timothy J. Horgan  
Regional Inspector General  
for Audit Services, Region II  
Department of Health and Human Services  
Jacob K. Javits Federal Building  
26 Federal Plaza  
New York, NY 10278

Re: Report No. A-02-02-01038

Dear Mr. Horgan:

We received the two copies of the U.S. Department of Health & Human Services, Office of Inspector General, Office of Audit Services' draft report entitled Review of Medicare Secondary Payor Processes at Lenox Hill Hospital for claims paid between July 1, 2001 and March 31, 2002. The Hospital has reviewed the report and the following comments are in response to the recommendations in the report.

Since 1998, Lenox Hill Hospital has conducted annual reviews of the Medicare Secondary Payor ("MSP") process, engaging outside consultants to assist with the annual review as well as conducting compliance reviews internally. The annual reviews resulted in standardizing the admitting and registration staff education on the MSP process; improving internal system controls to require the MSP questionnaire to be completed on-line and most recently has led to regular monitoring in addition to the annual audits to assure compliance with the MSP regulations. Also recent organizational changes have been implemented in response to the issues identified from this review. Please see attachment for the Hospital's responses to the Office of Inspector General's recommendation.

Lenox Hill Hospital is pleased that the Office of Inspector General has found that the Hospital's MSP processes were adequate and resulted in proper MSP determinations and properly filed Medicare Credit Balance Reports.

In regard to the Office of Inspector General's specific recommendations, Lenox Hill Hospital has reviewed these recommendations and implemented tighter internal controls to assure compliance with the Medicare Secondary Payor requirements.

Sincerely,

A handwritten signature in black ink, appearing to read 'Thomas E. Poccia', written over a white background.

Thomas E. Poccia  
Vice President and Chief Financial Officer

TEP:js

Recommendations	Actions
<ul style="list-style-type: none"> <li>• Provide additional training and supervision for its registrars in order to improve the quality and consistency of the MSP information.</li> </ul>	<ul style="list-style-type: none"> <li>• Continuing annual education on the requirements for compliance with the MSP regulations is mandated for all employees, existing and new hires that are involved in the registration or admitting process. In addition to the annual education, errors identified in the MSP on - going monitoring process require additional education for the employees involved in the errors.</li> </ul>
<ul style="list-style-type: none"> <li>• Improve the patient information in the computerized registration system so that current and accurate MSP information is readily available to those who need it.</li> </ul>	<ul style="list-style-type: none"> <li>• The Patient Management system retains the most current and accurate MSP data and is available to the registrars and financial screeners by doing a simple inquiry prior to creating a new registration. The recent established on-going monitoring program will reduce or eliminate inaccurate MSP information.</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure that the Medicare program is reimbursed \$10,691 for the improper payments identified in this audit.</li> </ul>	<ul style="list-style-type: none"> <li>• An adjustment claim has been submitted to the Medicare program for the cases in which Medicare was billed as primary in error.</li> </ul>
<ul style="list-style-type: none"> <li>• Ensure that pending adjustments, such as the credit balance of \$13,066 identified through this audit, are included in its CMS-838.</li> </ul>	<ul style="list-style-type: none"> <li>• The Business office procedure for reporting pending adjustments has resulted in the timely liquidation of Medicare credit balances. We have tightened our process even further to insure that all credit balances are reported in the appropriate reporting quarter.</li> </ul>
<ul style="list-style-type: none"> <li>• Place greater emphasis on the importance of CMS-838 reporting requirements through a tightening of relevant policies and procedures.</li> </ul>	<ul style="list-style-type: none"> <li>• The Hospital's procedure on reporting credit balances on the CMS-838 report has been improved with increased monitoring to insure timely reporting.</li> </ul>

# ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy J. Horgan, *Regional Inspector General for Audit Services*. Other principal Office of Audit Services staff who contributed include:

## **New York**

Elliot Hirshon, *Audit Manager*

Stephen Hobday, *Auditor-in-Charge*

Sarah Cohen, *Auditor*

Peter DiStefano, *Auditor*

## **Headquarters**

Marianne Cholakian, *Audit Manager*