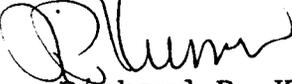


**Memorandum**

Date APR 15 1992
From 
Richard P. Kusserow
Inspector General

Subject Review of Medicare Credit Balances at Hospitals in South Carolina (A-04-91-02015)

To J. Michael Hudson
Acting Administrator
Health Care Financing Administration

This is to alert you to the issuance on April 17, 1992, of our final report. A copy is attached.

The report discloses that Medicare accounts receivable credit balances included unidentified overpayments totaling an estimated \$1.3 million for 17 hospitals in South Carolina serviced by Blue Cross and Blue Shield of South Carolina as the Medicare intermediary. The overpayments existed because neither the hospitals nor the intermediary reviewed credit balances or processed adjustments timely. We are recommending recovery of the overpayments and procedural improvements to ensure that the hospitals and the intermediary perform more timely reviews.

The Office of Inspector General is conducting a nationwide review of credit balances at eight intermediaries. This intermediary roll-up report is one of several that will be used to estimate the national magnitude of Medicare credit balance overpayments. The objective of our review was to determine if the credit balances represented overpayments and whether hospitals were refunding the overpayments to the intermediary within 60 days.

We selected, as a statistical sample, 8 of 17 South Carolina hospitals with 200 or more beds. Our review of credit balances at the eight hospitals showed that the hospitals received overpayments totaling \$553,960 which should have been refunded to the intermediary prior to our review. Projecting these results to the 17 hospitals, we estimate that hospitals have received \$1.3 million in Medicare overpayments and retained them for more than 60 days. The overpayments remained on the hospital records more than 60 days for several reasons: hospitals did not have adequate staff to review credit balances or adequate

Page 2 - J. Michael Hudson

procedures to review overpayments timely, and the intermediary and/or hospitals did not process adjustments timely.

We are recommending that the South Carolina intermediary assign a higher priority to processing adjusted claims, enhance claims processing, improve audit coverage, continue providing instructions to hospitals on proper filing of adjustments, and follow-up on questionable hospital practices cited in our report.

We issued separate reports to each of the eight hospitals. We also provided a draft of this roll-up report to intermediary officials for their review and comment. The intermediary essentially agreed with the findings and recommendations but cautioned that corrective action, in some instances, would depend on the Health Care Financing Administration's willingness to provide sufficient administrative funding.

For further information contact:
Emil A. Trefzger, Jr.
Regional Inspector General
for Audit Services, Region IV
FTS: 841-6229

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE CREDIT
BALANCES AT HOSPITALS IN
SOUTH CAROLINA**



**Richard P. Kusserow
INSPECTOR GENERAL**

A-04-91-02015

OFFICE OF INSPECTOR GENERAL

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

Common Identification Number A-04-91-02015

Mr. William R. Horton
Vice President - Medicare Operations
Blue Cross Blue Shield of South Carolina
300 Arbor Lake Drive
Suite 400
Columbia, South Carolina 29223

Dear Mr. Horton:

This report provides you with the results of our Review of Medicare Credit Balances at Hospitals in South Carolina. A Medicare credit balance occurs when reimbursements for services provided to a Medicare beneficiary exceed the charges billed according to the provider's accounting records. The objective of our review was to determine if hospital credit balances represented Medicare overpayments and whether the hospitals were refunding overpayments to Blue Cross Blue Shield of South Carolina (BCBS) within 60 days.

Our review at eight hospitals showed that Medicare regulations for refunding overpayments to BCBS were not always followed. Some hospitals identified Medicare overpayments and initiated corrective action. However, overall, hospitals did not routinely review their Medicare credit balances to identify Medicare overpayments, nor did they assure that overpayments were returned to BCBS timely. Records at the eight hospitals in our review indicated that the hospitals had received Medicare overpayments totaling \$553,960 which should have been refunded prior to our review. Projecting the results of our review, we estimate that 17 South Carolina hospitals have received and retained an estimated \$1.3 million in Medicare overpayments.

The overpayments remained on hospital records for more than 60 days for several reasons. Some hospitals did not have adequate staff to review credit balances. Some hospitals did not have procedures to assure that Medicare credit balances were reviewed and to assure that overpayments were refunded timely. Some hospitals that submitted adjustments could not clear their credit balances because BCBS had not processed the adjustments in a timely manner. Additionally, BCBS does not evaluate hospital procedures for reviewing credit balances. In our opinion, procedural improvements are needed at the hospitals

and at BCBS to ensure that Medicare overpayments are identified and refunded timely.

BACKGROUND

The Social Security Act Amendments of 1983 (Public Law 98-21) established the Prospective Payment System (PPS) of reimbursement to hospitals participating in the Medicare program. Under PPS, hospitals are reimbursed prospectively on a per discharge basis. However, certain types of costs, including outpatient services, are excluded from the hospitals' PPS reimbursements and are reimbursed on a reasonable cost basis. Hospitals are reimbursed for inpatient and outpatient services by fiscal intermediaries. These intermediaries are under contract with the Health Care Financing Administration (HCFA) to make Medicare payments. Intermediaries are required to audit hospital cost reports to ensure that the costs adhere to Federal regulations and HCFA guidelines. The intermediary for the hospitals in our review is BCBS.

A credit balance in a Medicare account receivable occurs when a hospital records a higher reimbursement than the amount charged for a specific Medicare beneficiary. A credit balance does not necessarily mean an overpayment has occurred. Some Medicare credit balances result from accounting errors and errors in calculating coinsurance amounts. These types of errors generally do not result in overpayments. Other Medicare credit balances result from duplicate payments made by an intermediary, payments made for an anticipated service that was not actually provided, or from payments made by an intermediary and other insurers for the same service provided to the same patient. In these cases, a Medicare overpayment exists and should be refunded to the intermediary.

SCOPE

Our review was made in accordance with generally accepted Government auditing standards. The objective of our review was to determine if the Medicare credit balances recorded on hospital records represented Medicare overpayments and if hospitals were refunding the overpayments to BCBS within 60 days.

Our review is part of a nationwide review on Medicare credit balances being controlled by the Region III Office of Audit Services (OAS). Region III randomly selected eight intermediaries nationwide and eight hospitals served by each intermediary. In Region IV, BCBS was the intermediary selected.

To estimate the overpayments due to BCBS, we used a multistage sample to project our results at the eight hospitals reviewed. The primary sampling unit was a hospital and the secondary sampling unit was a credit balance. We considered inpatient and outpatient credit balances separate universes. We further limited our review to outpatient credit balances over \$100 and inpatient credit balances over \$1,000. If a hospital had less than 100 such credit balances in a universe, we included all the credit balances in our review. Our review included only Medicare credit balances on the eight hospitals' records at the time of our review. For hospitals with more than 100 credit balances in each respective universe, we reviewed all inpatient credit balances of \$1,000 or more and randomly selected 100 outpatient credit balances of \$100 or more except that in one hospital we reviewed 100 percent of the outpatient credit balances of \$100 or more. This hospital had 117 outpatient credit balances of \$100 or more.

Our review was also limited to hospitals with over 200 beds. There were 17 such hospitals in South Carolina. We projected the results of our eight hospital reviews to the universe of 17 hospitals using the difference estimator. The Department of Health and Human Services (HHS), Office of Inspector General (OIG), OAS multistage software programs were used to make the projections. Our projections and recommended adjustments were limited to overpayments over 60 days old.

To distribute our projected overpayments to three categories representing the primary causes for the overpayments, we computed the percentage of the value of the overpayments in the primary cause category to the total overpayments identified at the eight hospitals. We then multiplied these percentages by the total projected overpayments for the 17 hospitals.

We analyzed the identified Medicare credit balances at the eight hospitals to determine if overpayments had occurred. We did this through review of such records as credit balance runs, patient files, remittance advices, hospital payment histories, and BCBS's payment histories.

We followed up our hospital reviews with a review at BCBS. When hospital records indicated an adjustment claim had been submitted to BCBS for an overpayment, we traced the overpayment to BCBS records to determine if BCBS had recouped the overpayment prior to our review. We also traced a judgmental sample of duplicate payments identified at the hospitals to BCBS records, to determine the reason for the duplicate

payments. We also reviewed BCBS's provider audit procedures to determine the extent that BCBS reviews hospital controls over credit balances.

Our field work was performed at the eight hospitals and at BCBS's offices in South Carolina during the period April 1991 to September 1991.

We provided a draft report to BCBS for comments. The intermediary's written comments are summarized following the conclusions and recommendations section, and included in their entirety as Appendix C.

RESULTS OF REVIEW

Our review showed that the hospitals did not always comply with Medicare regulations for refunding overpayments to BCBS. The hospitals established credit balances, in most cases reviewed the credit balances to determine if Medicare overpayments occurred, and in some cases, notified the intermediary of the overpayments. However, for the most part, the hospitals did not take steps to ensure that the identified overpayments were refunded to BCBS within 60 days.

The eight hospitals we reviewed had received Medicare overpayments totaling \$553,960 that should have been returned to the intermediary. Projecting our results, we estimate that the 17 hospitals in our universe have received and retained \$1.3 million in Medicare overpayments.

The hospitals were primarily responsible for not returning the Medicare overpayments within 60 days. However, BCBS's claims processing system, administrative decisions, and limited audit coverage of hospital credit balance procedures also contributed to the untimely recoupment of the Medicare overpayments.

We are recommending that BCBS expand its audit coverage over hospital credit balance procedures, assign a higher priority to the processing of adjustment claims, consider enhancing certain aspects of its claims processing, continue to provide instructions to providers on the proper filing of adjustments, and follow-up on the questionable hospital practices cited in our report.

Details of our reviews are presented below.

HOSPITAL REVIEWS

Our review of eight Medicare participating hospitals serviced by BCBS showed that all of the hospitals had Medicare credit

balances recorded on their accounting records at the time of our review.

We reviewed 996 Medicare outpatient and inpatient credit balances at the hospitals and found that 419 (42 percent) represented Medicare overpayments totaling \$553,960 (\$85,915 for outpatient services and \$468,045 for inpatient services). See Appendix A and Appendix B for individual hospital results.

Projecting the results of our hospital reviews, we estimate that \$1.3 million in credit balances over 60 days old, are owed to BCBS by the hospitals in our universe. The \$1.3 million represents the point estimate of our sample projections. The point estimate for the inpatient projection was \$994,595 with a standard error of \$292,130. The point estimate for the outpatient projection was \$326,358 with a standard error of \$111,871.

Additionally, we identified \$141,332 of overpayments at the eight hospitals which had not yet exceeded the 60 day time frame. We did not consider these as errors for our reviews, however, they will soon require refund action by the hospitals.

None of the \$553,960 had been recouped by BCBS prior to our review, however, some corrective actions sent by hospitals were in process at BCBS. The overpayments remained on hospital records for periods in excess of 60 days. Based on the date the credit balances in our review were established through the close of our review, we found that the hospitals retained the overpayments an average of 332 days.

For the most part, we found that the Medicare overpayments remained on the hospitals' records for long periods because the hospitals did not routinely review their Medicare credit balances to identify overpayments, nor did they assure that overpayments were returned to BCBS timely.

Our hospital reviews identified three primary causes for the Medicare overpayments, as described below.

Services Reimbursed by Another Insurer

We estimate that Medicare overpayments totaling \$1,028,201 resulted from hospitals billing Medicare and a commercial insurer for the same service and receiving primary payments from both. The Medicare Secondary Payer (MSP) provisions state that Medicare will not reimburse for services covered by another insurer. When the hospitals received payments from both insurers, the hospitals established credit balances for the excess reimbursements, but did not routinely resolve the credit balances. In these cases, we found that the other

insurer was primary and that the Medicare payments were overpayments to the hospitals.

Duplicate Billing of Services

We estimate that Medicare overpayments totaling \$197,295 resulted from hospitals submitting duplicate claims that went undetected by BCBS. We attributed 89 of the 419 overpayments found at the hospitals to duplicate billing.

We reviewed intermediary records applicable to a judgmental sample of 20 duplicate payments in an attempt to determine why BCBS did not detect the duplicate claims. We were able to determine a cause for 14 of the 20 duplicate payments. Our analysis of the these 14 is as follows:

- o Eight duplicate payments were the result of BCBS's claims processing. In these cases, BCBS personnel lifted a duplicate edit to allow the claim to process or the edit failed to catch the duplicate claim. We were not able to determine the cause of these edit failures.
- o Four duplicate payments occurred because hospitals submitted duplicate claims using different health insurance claim numbers, different bill types or dates of service for the same service.
- o Two duplicate payments occurred because the hospital submitted both an inpatient and outpatient claim for the same service and received an inpatient and an outpatient payment. These payments occurred prior to December 3, 1990 when BCBS did not have a computer cross match between inpatient and outpatient claims.

Although we only found reasons for 14 duplicate payments at the intermediary, we believe these are the primary reasons for the duplicate payments to the hospitals. The hospital records for the 14 overpayments reviewed were representative of the records for the 89 overpayments in this category.

Services Not Performed

We estimate that Medicare overpayments totaling \$90,266 resulted from billing for services not performed. Usually, this occurred when hospitals prepared and submitted a claim anticipating that a service would be performed. Subsequent to submitting the claims to BCBS, the hospitals became aware that the services were not performed and cancelled the charges.

Since the Medicare reimbursements exceeded the hospitals' charges, the hospitals established Medicare credit balances but did not return the overpayments.

INTERMEDIARY REVIEW

Some of the hospitals expressed concerns that BCBS was a contributing factor to the problem of unresolved credit balances and outstanding overpayments. Therefore, we followed-up our hospital reviews with a limited review at BCBS. We reviewed BCBS's processing of adjustment claims and provider audit coverage of hospital credit balance procedures. We found that BCBS practices did contribute to the existence of Medicare overpayments at the hospitals. Following are details of our review at BCBS.

Processing Of Adjustment Claims

Some hospitals informed us that they had submitted adjustments to BCBS for the overpayments we identified but had not received notice from BCBS indicating that the overpayments had been recouped. The hospitals felt they were not responsible for the length of time these overpayments were on their records. To determine if adjustment claims had been received and processed by BCBS, we traced 43 electronically transmitted (EMC) adjustment claims submitted by the hospitals to BCBS records. We reviewed EMC adjustment claims because the hospitals provided us with documentation (strips) showing that BCBS had electronically acknowledged receipt of the adjustments.

We found that 25 of these adjustments were accepted for processing by BCBS. However, the adjustments were not processed timely. The 25 adjustment claims took an average of 134 days to enter the system, beginning from the date of the adjustment strip to the date it was accepted for processing. These results indicated that BCBS's processing time was a contributing factor to the length of time overpayments remained on hospital records.

The remaining 18 adjustments in our review either did not represent an appropriate adjustment to recoup an overpayment or they were not on BCBS's claims processing system. Most of these were the results of hospital errors, such as providing the wrong dates of service or providing the wrong value code on the adjustment claim. These results indicated that the hospitals were also a contributing factor to the continued existence of Medicare overpayments.

We discussed the processing of adjustment claims with BCBS personnel. We were provided additional information which leads us to believe that BCBS operations are a contributing factor to the existence of Medicare overpayments at the hospitals.

The BCBS processes MSP related claims separately from other claims. Officials at BCBS informed us that MSP adjustment claims were not processed on a routine basis because of a lack of priority assigned to processing them. Since MSP related overpayments represented 68 percent of the errors found in our reviews, we believe this low priority by BCBS has been a deterrent to the timely recoupment of these overpayments.

We were informed of a system limitation which negates hospital communications to BCBS and hampers the processing of adjustment claims. Each claim form, including those for adjustments, has a "remark" section that gives the hospital an opportunity to provide comments or explain the reason for the claim or adjustment to the intermediary. For example, we noted remarks such as "...Medicare is secondary, Medicare needs to take back their payment as primary payor." However, officials at BCBS informed us that when a claim is electronically submitted the remarks section is not accessible and cannot be read by processing personnel. Additionally, when a claim is identified as being MSP related, a facsimile of the claim is printed and sent to the MSP section for processing. Again, the remarks section is omitted from the facsimile due to this system limitation. Without this information the processor may be unaware of vital information needed to process the claim correctly. During our review, we noted several instances of incorrectly processed adjustments which could have been prevented had the remarks section been available.

We were also informed of a claims processing practice wherein BCBS turns off first pass edits to speed the acceptance of claims. Thus, the system automatically accepts the EMC adjustment claim and provides the hospital with an acknowledgement strip. This leads the hospital to believe that the adjustment has been accepted for processing. Later, BCBS subjects the adjustment claim to the edit and, if it fails the edit, the adjustment is not processed. However, when this happens, the hospital is not informed that the submitted adjustment was not processed. In the absence of communications to the hospital, the hospital does not know that additional corrective action is necessary to clear the overpayment.

Provider Audit Of Cost Reports

We believe another reason for credit balances existing for such long periods on hospital records is because BCBS performs limited monitoring of hospital credit balances and does not review hospital credit balance procedures.

The BCBS reviews hospital Medicare credit balance accounts through its audits of hospital cost reports. These audits require BCBS to ensure that hospitals properly report payments by primary payers when Medicare is a secondary payer (MSP situations). This MSP review is accomplished by sampling credit balance accounts and obtaining an explanation for the credit balances. Identified MSP overpayments are referred to BCBS's MSP section for adjustments. However, the BCBS reviews do not include an evaluation of hospital procedures over Medicare credit balances. The BCBS reviews do not assure that the hospitals routinely review their credit balances and refund overpayments timely.

Additionally, we found that the BCBS reviews of credit balances were limited due to time constraints. According to BCBS personnel, BCBS does not audit every hospital annually. During fiscal year ended September 30, 1989, BCBS audited only 37 of 78 hospitals it services.

We reviewed recently completed BCBS audits and audits in process for the eight hospitals in our review. The BCBS audits covered fiscal years 1988 and 1989. We found that the BCBS audits did not evaluate hospital procedures for reviewing credit balances. Additionally, four of the audits either did not include or did not plan to include an MSP review, thus no credit balances will be reviewed at these hospitals.

OTHER HOSPITAL PRACTICES

During our review, we found some questionable hospital practices which we believe should be brought to your attention. We did not perform detailed analyses of these practices but, if not corrected they could result in Medicare overpayments being lost in a hospital's records and never being refunded.

We found two hospitals, Baptist Medical Center (BMC) and Spartanburg Regional Medical Center (SRMC), that adjust their Medicare credit balances to a zero balance by charging the amount of the credit balance to such accounts as "Miscellaneous discount-due to age" or "Contractual Allowance Account." This practice is done at SRMC prior to assuring that any Medicare overpayments, which may have caused the credit balance, have been recouped by BCBS. Subsequent to these write-offs at SRMC, the audit trail for Medicare payments applicable to the patient

accounts is difficult to follow. Once the credit balances are zeroed out, there is no indication on the patient accounts that Medicare overpayments existed.

We also found an account at BMC entitled "Old Medicare Adjustment Account" which contained 71 Medicare duplicate overpayments totaling \$2,618. Instead of correctly posting both payments to the patient's billing record, the hospital posted one payment to the billing record and one payment to this adjustment account. As a result, the patient account did not reflect a credit balance and there was no evidence of a Medicare overpayment. Further, BMC had not submitted any adjustment claims on these overpayments.

We found that McLeod Regional Medical Center (McLeod) maintained an unlocated checks account for Medicare payments which could not be matched with patient accounts. We found Medicare payments totaling \$11,290 in this account. McLeod officials indicated that when possible, letters were forwarded to the payer of each check in an attempt to identify the appropriate patient accounts. However, McLeod does not maintain documentation of these attempts.

CONCLUSIONS AND RECOMMENDATIONS

We found Medicare credit balances at all eight hospitals representing \$553,960 of Medicare overpayments which should have been returned to BCBS prior to our review. Projecting our results, we estimate that hospitals have retained as much as \$1.3 million of Medicare overpayments in beneficiary accounts with credit balances.

The hospitals were primarily responsible for returning Medicare overpayments to BCBS. For the most part, the overpayments existed because the hospitals did not always review their credit balances to determine if overpayments were made nor did they routinely follow-up on overpayments to assure that the overpayments were returned to BCBS within 60 days. Two of the hospitals zeroed out their credit balances by charging the possible overpayment to other accounts. Additionally, when the hospitals did take action to correct an overpayment, we found that the hospitals did not always submit the correct information to BCBS.

Our review also found that BCBS practices contributed to the existence of Medicare overpayments in hospital credit balances. In our opinion, the adjustment claims we reviewed were not processed timely by BCBS. Additionally, the low priority assigned to MSP adjustment claims and claims processing system limitations relative to edits and hospital remarks also

contributed to the continued existence of Medicare credit balances and overpayments at the hospitals.

We believe procedural improvements are needed at the hospitals and at BCBS if Medicare overpayments are to be identified and refunded timely. We recommend that BCBS:

1. Expand its audit coverage to include a review of hospital procedures over Medicare credit balances and the timely refunding of overpayments.
2. Assign a higher priority to the processing of adjustment claims so they are processed more timely.
3. Consider claims processing enhancements which would allow provider remarks on Medicare claims to be read by claims personnel.
4. Consider establishing a reporting mechanism that makes providers aware of adjustment claims which are not accepted and emphasize to providers the importance of providing accurate information on adjustment claims.
5. Take action necessary to recover credit balance overpayments that we estimate to be \$1.3 million.
6. Follow up on the questionable hospital practices cited in our report.

Auditee Comments

The BCBS concurred with all our recommendations and noted steps had already been implemented or will shortly be undertaken to resolve each of the matters addressed. However, the BCBS stated that some of the OIG's recommendations will prove difficult during a period of decreased Federal funding to contractors with no corresponding decrease in responsibilities. The entire text of the auditee's comments is included as Appendix C.

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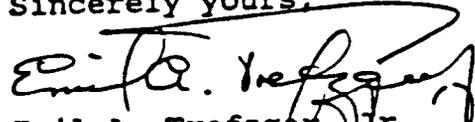
In accordance with the principals of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise.

Page 12 - William R. Horton

The HHS action official will contact you to resolve the issues in this audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time.

If you have any questions regarding this report, please call Gerald Dunham at (404) 331-2446. Please refer to the above Common Identification Number in any correspondence regarding this report.

Sincerely yours,



Emil A. Trefzger, Jr.
Regional Inspector General
for Audit Services

Appendices (3)

APPENDIX

Appendix A

INPATIENT CREDIT BALANCES
RESULTS OF HOSPITAL REVIEWS

| <u>HOSPITAL</u> | <u>NUMBER OF CREDIT BALANCES REVIEWED</u> | <u>OVERPAYMENTS</u> | |
|--|---|---------------------|----------------|
| | | <u>NUMBER</u> | <u>AMOUNT</u> |
| BAPTIST MEDICAL CENTER | 132 | 83 | \$214,608 |
| LEXINGTON MEDICAL CENTER | 20 | 8 | 23,977 |
| MCLEOD REGIONAL MEDICAL CENTER | 23 | 9 | 26,085 |
| ROPER HOSPITAL | 41 | 16 | 40,724 |
| SPARTANBURG REGIONAL MEDICAL CENTER | 8 | 1 | 3,152 |
| ST. FRANCIS XAVIER HOSPITAL | 44 | 15 | 59,230 |
| TRIDENT REGIONAL MEDICAL CENTER | 47 | 32 | 73,624 |
| TUOMEY REGIONAL MEDICAL CENTER | 15 | 12 | 26,645 |
| TOTALS | <u>330</u> | <u>176</u> | <u>468,045</u> |

Appendix B

OUTPATIENT CREDIT BALANCES
RESULTS OF HOSPITAL REVIEWS

| <u>HOSPITAL</u> | <u>NUMBER OF CREDIT BALANCES REVIEWED</u> | <u>OVERPAYMENTS</u> | |
|--|---|---------------------|------------------|
| | | <u>NUMBER</u> | <u>AMOUNT</u> |
| BAPTIST MEDICAL CENTER | 100 | 52 | \$ 19,428 |
| LEXINGTON MEDICAL CENTER | 74 | 38 | 10,935 |
| MCLEOD REGIONAL MEDICAL CENTER | 117 | 33 | 13,996 |
| ROPER HOSPITAL | 71 | 27 | 13,570 |
| SPARTANBURG REGIONAL MEDICAL CENTER | 100 | 13 | 8,504 |
| ST. FRANCIS XAVIER HOSPITAL | 100 | 39 | 8,406 |
| TRIDENT REGIONAL MEDICAL CENTER | 82 | 38 | 10,895 |
| TUOMEY REGIONAL MEDICAL CENTER | 22 | 3 | 181 |
| TOTALS | <u>666</u> | <u>243</u> | <u>\$ 85,915</u> |

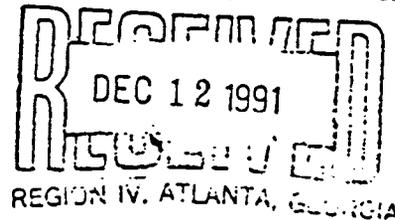


Handwritten signature

William R. Horton
Group Vice President
Federal Programs

300 Arbor Lake Drive
Suite 400
Columbia, S.C. 29223
(803) 754-1968

DHHS, OIG, Office of Audit Services



December 4, 1991

Mr. Emil A. Trefzger, Jr.
Regional Inspector General, OIG
Office of Audit Services
Post Office Box 2047
Atlanta, Georgia 30301

Dear Mr. Trefzger:

Thank you for the opportunity to comment on the draft report for the audit on Medicare credit balances in South Carolina hospitals. We have several comments and clarifications that should be considered by you before the final report is released.

1. We implemented a new EDP bill processing system on December 3, 1990. Many of the adjustments in your sample were for bills processed under our old system. In addition we converted to the HCFA Common Working File (CWF) process at the same time we implemented the new processing system. We anticipated problems in processing adjustment bills effective December 3, 1990 as a result of the new system and CWF process. Therefore, prior to implementation we made an effort to clean out as many Part A adjustments as possible. Since implementation we have put priority on processing Part A adjustments. We have also requested and received permission from HCFA to process certain adjustments outside of CWF. The pending workload statistics shown below support the fact that we are giving Part A adjustments priority processing.

Pending Adjustments

| | | | | | |
|----------|---|-------|----------|---|-------|
| 10/31/90 | - | 2,115 | 05/31/91 | - | 4,924 |
| 11/30/90 | - | 757 | 06/30/91 | - | 4,913 |
| 12/31/90 | - | 1,442 | 07/31/91 | - | 5,631 |
| 01/31/91 | - | 1,538 | 08/31/91 | - | 4,884 |
| 02/28/91 | - | 2,773 | 09/30/91 | - | 3,604 |
| 03/31/91 | - | 3,554 | 10/31/91 | - | 3,064 |
| 04/30/91 | - | 4,148 | 11/30/91 | - | 2,511 |

Mr. Emil A. Trefzger, Jr.
December 4, 1991
Page two

2. We have not turned off any edits in our system. Under our old bill processing system utilized prior to December 3, 1990, all adjustments submitted electronically by providers were processed electronically without any manual intervention. All bill edits were performed up front by the system. With our new processing system implemented on December 3, 1990, adjustments submitted electronically by providers are not processed without manual intervention. These electronic adjustments are received and a hard copy bill is prepared by the system. The hard copy then has to be entered into the system by claims personnel. The bill edits are performed by the system after they have been entered by claims personnel. This should explain why providers receive an acceptance slip when they transmit the bill electronically and later receive notice that the bill has not passed all system edits.

We currently have an enhancement outstanding to automate the processing of adjustment bills through the new system. This enhancement should be implemented early in calendar year 1992.

3. The number of credit balances would be significantly reduced if providers conformed with their conditions of participation and identified other payers up front and did not bill Medicare until the other identified payers made payment. We will work with providers to encourage a change in their billing procedures.
4. Continual funding reductions for Medicare contractors, especially in MSP and Provider Audit, severely impacts the contractors ability to process adjustments timely and to audit provider credit balances.
5. CWF problems have significantly impacted processing adjustments timely. Several CWF enhancements are scheduled by HCFA to solve these problems.

Mr. Emil A. Trefzger, Jr.
December 4, 1991
Page three

— Attached is an exhibit which outlines our responses to the specific recommendations made in the draft report. Should you need additional information or clarification on any of the items in this response, please contact Leon Myers of my staff at (803) 425-4534.

Sincerely,

William T. Horton

WRH/amb

Attachment

OIG RECOMMENDATIONS
CREDIT BALANCE ADJUSTMENTS

Recommendation Number 1

Expand its audit coverage to include a review of hospital procedures over Medicare credit balances and the timely refunding of overpayments.

BCBSSC Response

Generally we agree that the recommendation has merit and will, to the extent practicable, expand our activity in these areas.

While agreeing with this recommendation, the record would not be complete without drawing your attention to the fact that expanded audit coverage will prove difficult in a period of decreasing audit funding. In the current fiscal period (FY 1992) the funding available to both our cost report audit function and our MSP audit function is in fact less than in prior fiscal periods. The audit responsibilities which we are expected to carry out have not been decreased. Our ability to adequately address literally hundreds of "audit" issues within the decreasing funding levels appropriated to the audit task is at or near capacity. Nevertheless, we will include an expanded review of credit balances in a growing list of responsibilities competing for shrinking audit resources.

Recommendation Number 2

Assign a higher priority to the processing of adjustment claims so they are processed more timely.

BCBSSC Response

We agree with this recommendation. The Part A Bill Processing Adjustment area was reorganized in September 1991. Adjustment staff now consists of two (2) full-time employees and two (2) part-time employees. Prior to the reorganization adjustment staff consisted of one (1) full-time and one (1) part-time employee. This level of activity will continue until the adjustment workloads are back to normal levels.

Within the MSP department, there are 1,176 adjustments pending. Additional resources will be dedicated to processing MSP adjustment bills until the backlog is reduced to normal levels. After the backlog of MSP adjustment bills is reduced, sufficient resources will be dedicated to adjustment bill processing to ensure timely processing of provider submitted adjustment bills. Due to the systematic reduction over time of MSP funding, other MSP activities may have to be reduced to facilitate an adequate allocation of resources to MSP adjustment bill processing. We have developed reports to allow us to better control and track adjustments.

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BCBSSC Response Number 2 (Con't)

The following analysis of MSP per bill funding points to the systematic reduction of MSP funding over time. Over the same time period, required MSP activities and processing complexities have increased. The HCFA shared systems initiative also had a significant adverse impact on MSP processing due to the loss of automated functions with the implementation of new shared maintenance systems.

| | | |
|---------------------------------------|---------|---------|
| MSP per bill ongoing activity funding | FY 1992 | \$.2091 |
| | FY 1991 | .3188 |
| | FY 1990 | .3603 |
| | FY 1989 | \$.3727 |

Recommendation Number 3

Consider claims processing enhancements which would allow providers remarks on Medicare claims to be read by claims personnel.

BCBSSC Response

We agree with this recommendation and have initiated the necessary system modification to allow provider remarks on adjustments to be utilized by claims personnel.

Recommendation Number 4

Consider establishing a reporting mechanism that makes providers aware of adjustment claims which are not accepted, and emphasize to providers the importance of providing accurate information on adjustment claims.

BCBSSC Response

We agree with this recommendation. The following procedures have been implemented as a result of the OIG audit.

Adjustments that cannot be processed because of a provider error are returned to the provider with a cover letter explaining the corrective action necessary.

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BCBSSC Response Number 4 (Con't)

- . All adjustments returned to providers are logged in and controlled for follow-up activities. Should the provider fail to return the corrected adjustment coordination between claims personnel and provider reimbursement personnel is effectuated to ensure recoupment of credit balance from cost reports.
- . Part A Advisories are sent to providers pointing out the requirements and importance of submitting adjustments accurately and timely.

Recommendation Number 5

Take necessary action to recover credit balance overpayments that we estimate to be \$1.3 million.

BCBSSC Response

We agree with this recommendation. During the summer of 1991 HCFA issued instructions to all Medicare Part A Contractors establishing priority procedures for recoupment of credit balances. We have aggressively implemented these instructions. As a result of this project we have recouped \$2,744,823.87 from all types of Part A providers. We will continue the recovery process until all credit balances have been recouped.

Recommendation Number 6

Follow-up on the questionable hospital practices cited in our report.

BCBSSC Response

We agree with this recommendation. Several methods will be utilized to implement this recommendation.

- . Questionable practices will be addressed in advisories to all Part A providers.
- . These issues will be on the agenda at forthcoming provider workshops.
- . Individual contacts will be made to those providers demonstrating a pattern of questionable billing practices.