



DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

September 3, 2008

Report Number: A-05-08-00027

Ms. Sandy Miller
President
National Government Services
8115 Knue Road
Indianapolis, IN 46250

Dear Ms. Miller:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High Dollar Payments for Inpatient Services Processed by National Government Services in Illinois, Indiana, Kentucky, and Ohio for Calendar Years 2004 Through 2006 – Hospitals with Less Than 10 High Dollar Payments." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Steve Slamar, Audit Manager at (312) 353-7905 or through e-mail at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-07-00027 in all correspondence.

Sincerely,


Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HIGH DOLLAR
PAYMENTS FOR INPATIENT
SERVICES PROCESSED BY
NATIONAL GOVERNMENT
SERVICES IN ILLINOIS, INDIANA,
KENTUCKY, AND OHIO FOR
CALENDAR YEARS 2004
THROUGH 2006 – HOSPITALS
WITH LESS THAN 10 HIGH
DOLLAR PAYMENTS**



Daniel R. Levinson
Inspector General

September 2008
A-05-08-00027

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare and Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries to process and pay Medicare Part A claims submitted by hospitals. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process claims. The Common Working File can detect certain improper payments during prepayment validation.

Section 1886(d) of the Act established the prospective payment system (PPS) for inpatient hospital services. Under the PPS, CMS pays hospital costs at predetermined rates for patient discharges based on the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The "Medicare Claims Processing Manual," Pub. No. 100-04, Chapter 3, section 10.1, requires that hospitals submit claims on the appropriate forms for all provider billings, and Chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient services. Section 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides that PPS hospitals receive payment, in addition to the basic DRG payment, for blood clotting factor administered to hemophilia inpatients. Also, section 1886(d)(5)(A)(ii) of the Act provides for an additional payment, known as an outlier payment, to hospitals for cases incurring extraordinarily high costs.

During calendar years (CY) 2004 through 2006, AdminaStar Federal was the fiscal intermediary for Illinois, Indiana, Kentucky, and Ohio. AdminaStar Federal processed approximately 5.2 million inpatient claims during this period, 169 of which resulted in payments of \$200,000 or more (high-dollar payments). These high-dollar payments, totaling \$63,502,261, were made to hospitals that each received less than 10 such payments during our audit period. In January 2007, National Government Services assumed the business operations of AdminaStar Federal.

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that National Government Services made to hospitals for inpatient services were appropriate.

SUMMARY OF FINDING

Of the 169 high-dollar payments that the National Government Services made to hospitals for inpatient services for CYs 2004 through 2006, 74 were appropriate. The remaining 95 payments included net overpayments totaling \$19,939,124. At the start of our audit, hospitals had:

- refunded overpayments totaling \$19,263,785 for 2 claims and

- not refunded net overpayments totaling \$675,339 for 93 claims.

Contrary to Federal guidance, hospitals inaccurately reported units of service, reported incorrect charges that resulted in inappropriate outlier payments, or did not maintain supporting documentation. Hospitals attributed most of the incorrect claims to data entry errors, insufficient documentation to support charges, or a lack of documentation. National Government Services made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place to detect and prevent the inappropriate payments.

RECOMMENDATIONS

We recommend that National Government Services:

- recover the \$675,339 in identified net overpayments,
- use the results of this audit in its provider education activities related to data entry procedures and proper documentation, and
- consider implementing controls to identify and review of all payments greater than \$200,000 for inpatient services.

NATIONAL GOVERNMENT SERVICES COMMENTS

In its comments on our draft report, National Government Services agreed with our recommendations. National Government Services comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part A claims submitted by hospitals. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process hospitals' inpatient claims. The Common Working File can detect certain improper payments during prepayment validations.

In calendar years (CY) 2004 through 2006, fiscal intermediaries processed and paid approximately 40.6 million inpatient claims, 8,287 of which resulted in payments of \$200,000 or more (high-dollar payments).

Claims for Inpatient Services

Section 1886(d) of the Act established the prospective payment system (PPS) for inpatient hospital services. Under the PPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. The "Medicare Claims Processing Manual," Pub. No. 100-04, Chapter 3, section 10.1, requires that hospitals submit claims on the appropriate forms for all provider billings, and Chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

Section 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides that PPS hospitals receive payment, in addition to the basic DRG payment, for blood clotting factor administered to hemophilia inpatients. Also, section 1886(d)(5)(A)(ii) of the Act provides for an additional Medicare payment, known as an outlier payment, to hospitals for cases incurring extraordinarily high costs.¹ The Medicare fiscal intermediary identifies outlier cases by comparing the estimated costs of a case with a DRG-specific fixed-loss threshold.² To estimate the cost of a case, the fiscal intermediary uses the Medicare charges that the hospital reports on its claim and the hospital-specific cost-to-charge ratio. Inaccurately reporting charges could lead to excessive outlier payments.

¹Outlier payments occur when a hospital's charges for a particular Medicare beneficiary's inpatient stay substantially exceed the DRG payment.

²A DRG-specific fixed-loss threshold is a dollar amount by which the costs of a case must exceed payments to qualify for an outlier payment.

National Government Services

During our audit period (CYs 2004 through 2006), AdminaStar Federal was the fiscal intermediary in Illinois, Indiana, Kentucky, and Ohio. AdminaStar Federal processed approximately 5.2 million inpatient claims during this period, 169 of which resulted in high-dollar payments. These high-dollar payments, totaling \$63,502,261, were made to hospitals that each received less than 10 such payments during our audit period. In January 2007, National Government Services assumed the business operations of AdminaStar Federal.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that National Government Services made to hospitals for inpatient services were appropriate.

Scope

We reviewed the 169 high-dollar payments, which totaled \$63,502,261, for inpatient claims that National Government Services processed during CYs 2004 through 2006. We limited our review to the high dollar payments that were made to hospitals that each received less than 10 such payments during our audit period. We limited our review of National Government Services' internal controls to those applicable to the 169 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our fieldwork from December 2007 through May 2008. Our fieldwork included contacting National Government Services and the hospitals that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations and guidance;
- used CMS's National Claims History file to identify inpatient claims with high-dollar Medicare payments;
- reviewed available Common Working File claim histories for claims with high-dollar payments to determine whether the claims had been cancelled or superseded by revised claims and whether payments remained outstanding at the time of our fieldwork;

- contacted the hospitals that received the high-dollar payments to determine whether the information reported on the claims was correct and, if not, why the claims were incorrect and whether the hospitals agreed that refunds were appropriate; and
- validated with National Government Services that partial overpayments occurred and refunds were appropriate.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the 169 high-dollar payments that the National Government Services made to hospitals for inpatient services for CYs 2004 through 2006, 74 were appropriate. The remaining 95 payments included net overpayments totaling \$19,939,124. At the start of our audit, hospitals had:

- refunded overpayments totaling \$19,263,785 for 2 claims and
- not refunded net overpayments totaling \$675,339 for 93 claims.

Contrary to Federal guidance, hospitals inaccurately reported units of service, reported incorrect charges that resulted in inappropriate outlier payments, or did not maintain supporting documentation. Hospitals attributed most of the incorrect claims to data entry errors, insufficient documentation to support charges, or a lack of documentation. National Government Services made these inappropriate payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place to detect and prevent the inappropriate payments.

FEDERAL REQUIREMENTS

The “Medicare Claims Processing Manual,” Pub. No. 100-04, Chapter 3, section 10.1, requires that hospitals submit claims on the appropriate forms for all provider billings, and Chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

Section 6011 of the Omnibus Budget Reconciliation Act of 1989 (P. L. No. 101-239) provides that PPS hospitals receive an additional payment for the cost of administering a blood clotting factor to Medicare beneficiaries with hemophilia during an inpatient stay.³ The payment is based on a predetermined price per unit of clotting factor multiplied by the number of units provided.

³Section 6011(d) was amended by section 13505 of the Omnibus Budget Reconciliation Act of 1993 (P. L. No. 103-66) and section 4452 of the Balanced Budget Act of 1997 (P. L. No. 105-33) so that it is effective for discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997.

Section 1886(d)(5)(A)(ii) of the Act provides for Medicare outlier payments to hospitals, in addition to prospective payments, for cases incurring extraordinarily high costs. CMS provides for these additional payments, as specified in 42 CFR § 412.80, to hospitals for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges, as adjusted by the hospital-specific cost-to-charge ratio, exceed the DRG payment for the case.

Section 1815(a) of the Act prohibits Medicare payment for claims not supported by sufficient documentation. Medicare regulations at 42 CFR § 482.24 require hospitals to retain supporting documentation for at least 5 years.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

National Government Services made 95 net overpayments totaling \$19,939,124. Of this amount, hospitals refunded \$19,263,785 prior to the start of our audit, while \$675,339 had not been refunded. The following examples illustrate the inappropriate high-dollar payments:

- Hospitals reported inaccurate blood clotting factor units administered to hemophiliacs resulting in overpayments totaling \$19,298,615. For example, a hospital reported 171,350 units instead of the correct 1,714 units. As a result, National Government Services paid the hospital \$10,000,000 when it should have paid \$471,907, a \$9,528,093 overpayment.
- Hospitals reported incorrect charges for drugs, services, and supplies resulting in net overpayments totaling \$392,987 in outlier payments. For example, a hospital reported excessive pharmacy charges of \$10,860 for drugs on its claim. As a result, National Government Services overpaid the hospital \$3,108 in outlier payments.
- A hospital did not maintain any supporting records to substantiate one claim and overpayment totaling \$247,522.

CAUSES OF INAPPROPRIATE PAYMENTS

Hospitals attributed most of the incorrect claims to data entry errors, insufficient documentation to support charges, or a lack of documentation. National Government Services made these incorrect overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place to detect and prevent the overpayments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.⁴

⁴The fiscal intermediary sends an "Explanation of Medicare Benefits" notice to the beneficiary after the hospital files a claim for Part A service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

RECOMMENDATIONS

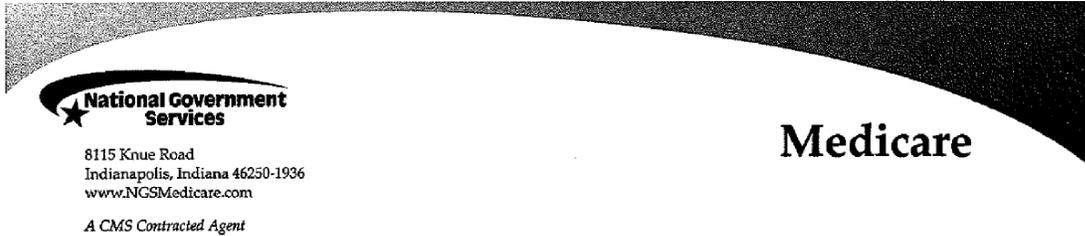
We recommend that National Government Services:

- recover the \$675,339 in identified net overpayments,
- use the results of this audit in its provider education activities related to data entry procedures and proper documentation, and
- consider implementing controls to identify and review all payments greater than \$200,000 for inpatient services.

NATIONAL GOVERNMENT SERVICES COMMENTS

In its comments on our draft report, National Government Services agreed with our recommendations. National Government Services comments are included in their entirety as the Appendix.

APPENDIX



August 28, 2008

Mr. Marc Gustafson
Regional Inspector General for Audit Services
Office of Inspector General, Region V
233 North Michigan Avenue
Chicago, IL 60601

Re: Response to Draft Report Number A-05-08-00027

Dear Mr. Gustafson:

This letter is in response to the above referenced draft report entitled "Review of Excessive Payments for Inpatient Services Processed by National Government Services in Illinois, Indiana, Kentucky, and Ohio for Calendar Years 2004 through 2006."

National Government Services (NGS) agrees with the audit recommendations noted in the draft report and offers the following comments.

1. The 93 claims representing overpayments of \$675,339 were adjusted and monies were recovered by May 30, 2008.
2. The information identified in this review will be shared with our Provider Outreach and Education Department to ensure providers are aware of correct billing procedures.
3. NGS has enhanced the controls around reviewing claims where the providers' reimbursement is greater than the normal tolerance level established for a provider so that further review can occur and reduce the potential for overpayments.

NGS appreciates the opportunity to respond to the draft report. Should you have further questions, please feel free to contact Sarah Litteral, Claims Director, at 502-329-8584.

Sincerely,

A handwritten signature in black ink that reads "David Crowley".

David Crowley
Staff Vice President
Claims Management

cc: Sarah Litteral, Part A/RHHI Claims Director

