



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

JUL 14 2008

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Report Number: A-07-08-04133

Mr. Guy Ringle
Senior Vice President
Medicare Division
Wisconsin Physicians Service
1717 West Broadway
Madison, Wisconsin 53713

Dear Mr. Ringle:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Wisconsin Physicians Service Insurance Corporation High-Dollar Payments for Medicare Part A Claims Processed by Blue Cross Blue Shield of Nebraska for the Period January 1, 2003, Through December 31, 2005." 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 Raylene Mason, Audit Manager, at (816) 426-3203 or through e-mail at Raylene.Mason@oig.hhs.gov. Please refer to report number A-07-08-04133 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Patrick J. Cogley", written over a large, stylized, scribbled-out signature.

Patrick J. Cogley
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 WISCONSIN
PHYSICIANS SERVICE INSURANCE
CORPORATION HIGH-DOLLAR
PAYMENTS FOR MEDICARE PART A
CLAIMS PROCESSED BY BLUE
CROSS BLUE SHIELD OF
NEBRASKA FOR THE PERIOD
JANUARY 1, 2003, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

July 2008
A-07-08-04133

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

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Providers generate the claims for inpatient and outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (PPS). Under the PPS, claims are paid a predetermined amount based on a patient's placement into a specific diagnosis-related group and an additional amount, known as an outlier, for stays that have extraordinarily high costs. Outpatient hospital services are paid based on the number of times that the service or procedure being reported was performed. Hospitals are required to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System.

To process providers' inpatient and outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

During our audit period (calendar years (CY) 2003 through 2005), Blue Cross Blue Shield of Nebraska, Inc. (BCBS), was the Medicare Part A fiscal intermediary serving Medicare providers in Nebraska. BCBS processed 168,298 inpatient claims and approximately 2.3 million outpatient claims during this period. Of these claims, BCBS processed 21 inpatient claims that had payments of \$200,000 or more and 14 outpatient claims that had payments of \$50,000 or more. We considered these high-dollar claims to be at high risk for overpayment.

On December 1, 2007, CMS awarded the Nebraska fiscal intermediary contract to Wisconsin Physicians Service Insurance Corporation (WPS). Although BCBS processed the Medicare Part A claims for the audit period we reviewed, WPS has since assumed responsibility as the Medicare Part A fiscal intermediary for Nebraska. Therefore, we are issuing our report to WPS because (a) BCBS no longer has access to the Medicare Part A processing system and (b) as the fiscal intermediary, WPS has assumed the responsibility to ensure that the claims have been corrected.

OBJECTIVE

Our objective was to determine whether high-dollar Medicare claims that BCBS processed and paid to Nebraska Part A providers for inpatient and outpatient services were appropriate.

SUMMARY OF FINDINGS

Eighteen of the twenty-one high-dollar inpatient claims that BCBS paid to providers were appropriate. However, BCBS overpaid one provider \$111,677 for the remaining 3 claims. One was an underpayment and 2 were overpayments, resulting in a net overpayment of \$111,677 that was outstanding at the start of our fieldwork.

Three of the fourteen high-dollar outpatient claims that BCBS paid to providers were appropriate. However, BCBS overpaid providers \$870,587 for the remaining 11 claims that remained outstanding at the start of our fieldwork.

Taken together, these incorrect high-dollar claims resulted in \$982,264 in overpayments that remained outstanding.

The providers attributed the incorrect high-dollar claims to clerical errors or to billing systems that could not detect and prevent the incorrect billing of units of service. In addition, BCBS processed incorrect provider claims because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2003 through 2005 to detect billing errors related to units of service.

RECOMMENDATIONS

We recommend that WPS:

- recover the \$982,264 in overpayments,
- use the results of this audit in its provider education activities, and
- identify and recover any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2005.

AUDITEE COMMENTS

In written comments on our draft report, WPS stated that it would comply with all of our recommendations. WPS's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Fiscal Intermediary Responsibilities

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for Inpatient and Outpatient Services

Providers generate the claims for inpatient and outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (PPS). In accordance with the PPS, fiscal intermediaries reimburse hospitals a predetermined amount depending on the illness and its classification under a diagnosis-related group (DRG). Inpatient stays that are extremely long or have extraordinarily high costs are eligible for an additional amount called an outlier payment.

The Medicare fiscal intermediary identifies outlier cases by comparing the estimated costs of a case to a DRG-specific fixed-loss threshold. Because hospitals cannot calculate the costs of cases individually, the fiscal intermediary uses the Medicare charges the hospital reported on its claim to estimate the cost of a case. Inaccurately reporting charges can lead to excessive outlier payments.

Outpatient hospital services are paid based on the number of times the service or procedure being reported was performed. Hospitals are required to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS).

To process providers' inpatient and outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

In calendar years (CY) 2003 through 2005, providers submitted approximately 40.9 million inpatient claims and approximately 409.4 million outpatient claims nationwide. Of the 40.9 million inpatient claims, only 8,253 claims resulted in payments of \$200,000 or more. Of the 409.4 million outpatient claims, only 1,243 claims resulted in payment of \$50,000 or more. We considered these high-dollar claims to be at high risk for overpayment.

Wisconsin Physicians Service Insurance Corporation

During our audit period, Blue Cross Blue Shield of Nebraska, Inc. (BCBS), was the Medicare Part A fiscal intermediary serving Medicare providers in Nebraska. During this period, BCBS processed 168,298 Nebraska Part A inpatient claims that had payments of approximately \$1.2 billion and approximately 2.3 million outpatient claims that had payments of approximately \$454 million. Of these claims, BCBS processed 21 inpatient claims and 14 outpatient claims that had high-dollar payments. On December 1, 2007, CMS awarded the Nebraska fiscal intermediary contract to Wisconsin Physicians Service Insurance Corporation (WPS).

The Social Security Act's definition of "provider of services" encompasses hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, renal dialysis facilities, and hospice programs. However, all providers with high-dollar claims processed during our audit period were hospitals; thus, the term "provider" as used in the remainder of this report refers to hospitals.

New Fiscal Intermediary Prepayment Edit

On January 3, 2006, after the end of our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends outpatient claims of \$50,000 or more and requires intermediaries to contact providers to determine the legitimacy of the claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare claims that BCBS processed and paid to Nebraska Part A providers for inpatient and outpatient services were appropriate.

Scope

We reviewed the 21 high-dollar inpatient claims totaling \$5,501,365 and 14 high-dollar outpatient claims totaling \$1,251,875 processed during CYs 2003 through 2005.

We limited our review of BCBS's internal control structure to those controls applicable to the 35 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 a 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 fieldwork from June through September 2007. Our fieldwork included contacting BCBS, located in Omaha, Nebraska, and the hospitals that received the payments for the high-dollar claims.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare Part A inpatient and outpatient claims with high-dollar payments;
- reviewed available Common Working File claims histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our fieldwork;
- coordinated our claims review with BCBS of Nebraska;
- contacted providers to determine whether the high-dollar claims were billed correctly;
- obtained documentation from the providers confirming all incorrect claims identified; and
- provided supporting documentation for all the incorrect claims identified to WPS on June 3, 2008.

Although BCBS processed the Medicare Part A claims for the audit period we reviewed, WPS has since assumed responsibility as the Medicare Part A fiscal intermediary for Nebraska. Therefore, we are issuing our report to WPS because (a) BCBS no longer has access to the Medicare Part A processing system and (b) as the fiscal intermediary, WPS has assumed the responsibility to ensure that the claims have been corrected.

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.

FINDINGS AND RECOMMENDATIONS

Eighteen of the twenty-one high-dollar inpatient claims that BCBS paid to providers were appropriate. However, BCBS overpaid one provider \$111,677 for the remaining 3 claims. One was an underpayment and 2 were overpayments, resulting in a net overpayment of \$111,677 that was outstanding at the start of our fieldwork.

Three of the fourteen high-dollar outpatient claims that BCBS paid to providers were appropriate. However, BCBS overpaid providers \$870,587 for the remaining 11 claims that remained outstanding at the start of our fieldwork.

Taken together, these incorrect high-dollar claims resulted in \$982,264 in overpayments that remained outstanding.

The providers attributed the incorrect high-dollar claims to clerical errors or to billing systems that could not detect and prevent the incorrect billing of units of service. In addition, BCBS processed incorrect provider claims because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2003 through 2005 to detect billing errors related to units of service.

FEDERAL REQUIREMENTS

Inpatient Claims

The Social Security Amendments of 1983 (Public Law 98-21) provided for the establishment of the PPS. In accordance with Medicare's PPS for inpatient acute care hospitals, reimbursement to hospitals for inpatient services furnished to beneficiaries is a predetermined amount, known as a DRG payment.

Section 1886(d)(5)(A) of the Social Security Act requires that Medicare pay hospitals an outlier payment in addition to the basic DRG amount to protect the hospital from incurring large financial losses due to unusually expensive cases. Furthermore, the CMS "Hospital Manual," section 462, states: "In order to be paid correctly and promptly, a bill must be completed accurately."

Section 3700 of the CMS "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

Outpatient Claims

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the HCPCS. Section 3627.8(C) of the "Medicare Intermediary Manual" states: "The definition of service units is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the 'number of times the service or procedure being reported was performed.'" Furthermore, the "Hospital Manual," section 462, states: "In order to be paid correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE INPATIENT HIGH-DOLLAR PAYMENTS

Three high-dollar claims, totaling \$111,677 in net overpayments, remained outstanding at the start of our fieldwork. The provider performed a detailed charge level review, which identified that, because of the patients' lengths of stay, the hospital prepared interim and final bills. The interim bills included multiple procedure codes that resulted in an allowable provider payment of \$853,677. However, the final bills overreported some items and underreported other items, resulting in an allowable provider payment of \$742,000. The billing error resulted in a provider overpayment of \$111,677.

INAPPROPRIATE OUTPATIENT HIGH-DOLLAR PAYMENTS

For the eleven high-dollar claims totaling \$870,587 which remained outstanding, providers incorrectly billed the units of service:

- For four claims, the provider billed 400 units of service when it should have billed 40 units, resulting in a provider overpayment of \$242,472.
- For one claim, the provider billed 3 units of service when it should have billed 1 unit, resulting in a provider overpayment of \$30,346.
- For four claims, the provider billed 250 units of service when it should have billed 1 unit, resulting in a provider overpayment of \$396,219.
- For two claims, the provider made multiple errors on the claim resulting in a provider overpayment totaling \$201,550:
 - On one claim, the provider billed 31 units of services when it should have billed 30 units, while on the same claim for another type of service, the provider billed 11 units when it should have billed 2 units.
 - On one claim, the provider billed 32 units of services when it should have billed 31 units, while on the same claim for another type of service, the provider billed 10 units when it should have billed 1 unit.

CAUSES OF INCORRECT PAYMENTS

The providers attributed the incorrect high-dollar claims to clerical errors or to billing systems that could not detect and prevent the incorrect billing of units of service. In addition, BCBS processed incorrect provider claims because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2003 through 2005 to detect billing errors related to units of service. CMS relied on providers to notify the intermediaries of excessive payments.

RECOMMENDATIONS

We recommend that WPS:

- recover the \$982,264 in overpayments,
- use the results of this audit in its provider education activities, and
- identify and recover any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2005.

AUDITEE COMMENTS

In written comments on our draft report, WPS stated that it would comply with all of our recommendations. WPS's comments are included in their entirety as the Appendix.

APPENDIX



Medicare

June 27, 2008

Patrick J. Cogley
Regional Inspector General for Audit Services
Region VII
601 East 12th Street
Room 284A
Kansas City, MO 64106

Re: OIG Blue Book Audit A-07-08-04133
June 2008

Dear Mr. Cogley:

This letter is in response to the Draft OIG Blue Book titled "Review of Wisconsin Physicians Service Insurance Corporation High-Dollar Payments for Medicare Part A Claims Processed by Blue Cross Blue Shield of Nebraska for the Period January 1, 2003 Through December 31, 2005". In your letter dated June 20, 2008 you requested our office to provide comments on each of the recommendations.

WPS assumed responsibility for the state of Nebraska and prior Blue Cross Blue Shield Nebraska's processing activity on December 1, 2007. We understand that your office has identified twenty high-dollar inpatient accounts and fourteen high-dollar outpatient accounts. Of these initial findings there are three inpatient and eleven outpatient claims that remain to be recovered for a total of \$982,264.00 in overpayments.

Recommendations

OIG recommends that WPS:

- recover the \$982,264 in overpayments,
- use the results of this audit in its provider education activities, and
- identify and recover any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2005.

WPS intends to recoup the overpaid amounts for the fourteen remaining claims. We will do this by adjusting the claims following normal adjustment procedures including abiding by the four-year reopening guidelines.

WPS will continue, as we have in the past, to employ the use of system edits to monitor claims for high dollar payments as well as potential excessive units. WPS also provides further safeguards by the reimbursement and claims areas monitoring all out-going checks for abnormalities in the payment tolerance levels of providers.



Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare contractor
P.O. Box 1787 • Madison, WI 53701 • Phone 608-221-4711



Medicare

If a scheduled payment is significantly over the normal the range for that provider, the remittance advice is investigated to determine the validity of payment. If applicable, payments are suspended pending further verification.

Our Provider Communications staff will use the results of this audit where applicable in our future provider education activities.

WPS will identify and recover any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2005.

WPS looks forward to working with you in the completion of this OIG Audit of high-dollar payments by Blue Cross Blue Shield of Nebraska. If you have any questions, or need any more information please contact Michelle Routt at 402-351-8293. You may also contact me at 402-351-6915.

Sincerely,

A handwritten signature in cursive script that reads "Mark DeFoil".

Mark DeFoil
Director Contract Coordination

cc: John Phelps, KCRO



Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare contractor
P.O. Box 1787 • Madison, WI 53701 • Phone 608-221-4711