



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

April 14, 2010

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of High-Dollar Payments for Inpatient Services Processed by Noridian Administrative Services, LLC, for the Period January 1, 2003, Through December 31, 2005 (A-07-09-04148)

Attached, for your information, is an advance copy of our final report on high-dollar payments for inpatient services processed by Noridian Administrative Services, LLC (Noridian), for the period January 1, 2003, through December 31, 2005. We will issue this report to Noridian within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Patrick J. Cogley, Regional Inspector General for Audit Services, Region VII, at (816) 426-3591 or through email at Patrick.Cogley@oig.hhs.gov. Please refer to report number A-07-09-04148.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

April 21, 2010

Report Number: A-07-09-04148

Mr. Jay Martinson
Executive Vice President, Chief Operating Officer
Noridian Administrative Services, LLC
900 42nd Street South
P.O. Box 6055
Fargo, ND 58103-2146

Dear Mr. Martinson:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of High-Dollar Payments for Inpatient Services Processed by Noridian Administrative Services, LLC, 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-09-04148 in all correspondence.

Sincerely,

/Patrick J. Cogley/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. 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, MO 64106

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR PAYMENTS
FOR INPATIENT SERVICES PROCESSED
BY NORIDIAN ADMINISTRATIVE
SERVICES, LLC, FOR THE PERIOD
JANUARY 1, 2003, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

April 2010
A-07-09-04148

Office of Inspector General

<http://oig.hhs.gov>

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The Office of Audit Services (OAS) provides 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. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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Notices

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Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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 aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & 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 for inpatient hospital services. Under the prospective payment system, CMS pays hospital costs at predetermined rates for patient discharges based on the diagnosis-related group 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 diagnosis-related group payment is, with certain exceptions, payment in full to the hospital for all inpatient services. 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) 2003 through 2005, Noridian Administrative Services, LLC (Noridian), was the fiscal intermediary serving Medicare providers in 11 States. Noridian processed approximately 2.6 million inpatient claims during this period, 415 of which resulted in payments of \$200,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDING

Of the 415 high-dollar payments that Noridian made to hospitals for inpatient services for CYs 2003 through 2005, 306 were appropriate. The 109 remaining payments included net overpayments totaling \$3,030,671. At the start of our audit, hospitals had refunded overpayments totaling \$1,144,709 but had not refunded net overpayments totaling \$1,885,962.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units of service, reported incorrect procedure codes, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of

service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2003 through 2005 to prevent or detect incorrect payments.

RECOMMENDATIONS

We recommend that Noridian:

- recover the \$1,885,962 in net overpayments,
- determine and recover the overpayment for one inpatient claim still under adjudication,
- use the results of this audit in its provider education activities, and
- consider implementing controls to identify and review all payments greater than \$200,000 for inpatient services.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Noridian's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Fiscal Intermediaries	1
Claims for Inpatient Services.....	1
Noridian Administrative Services, LLC	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope.....	2
Methodology.....	2
FINDING AND RECOMMENDATIONS	3
FEDERAL REQUIREMENTS	3
INAPPROPRIATE HIGH-DOLLAR PAYMENTS	4
CAUSES OF INAPPROPRIATE HIGH-DOLLAR PAYMENTS	4
RECOMMENDATIONS	5
NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS	5
APPENDIX	
NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS	

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 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.¹ 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 (CWF) to process hospitals' inpatient claims. The CWF can detect certain improper payments during prepayment validation.

In calendar years (CY) 2003 through 2005, fiscal intermediaries processed and paid approximately 40.9 million inpatient claims, 8,253 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 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.² The fiscal intermediary identifies outlier cases by comparing the estimated costs of a case with a DRG-specific fixed-loss threshold.³ To estimate the costs of a case, the fiscal intermediary uses the

¹ The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173 (MMA), which became effective on October 1, 2005, amended certain sections of the Act, including section 1816(a), to require that Medicare administrative contractors replace carriers and fiscal intermediaries by October 2011.

² Outlier payments occur when a hospital's charges for a particular Medicare beneficiary's inpatient stay substantially exceed the DRG payment.

³ A 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.

Medicare charges that the hospital reports on its claim and the hospital-specific cost-to-charge ratio. Inaccurately reporting charges can lead to excessive outlier payments.

Noridian Administrative Services, LLC

During our audit period (CYs 2003 through 2005), Noridian Administrative Services, LLC (Noridian), was the Medicare Part A fiscal intermediary serving Medicare providers in 11 States.⁴ Noridian processed approximately 2.6 million Part A inpatient claims during this period, 415 of which resulted in high-dollar payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 415 high-dollar payments for inpatient claims that Noridian processed during CYs 2003 through 2005. We limited our review of Noridian's internal controls to those applicable to the 415 high-dollar payments 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 fieldwork from July 2007 through April 2009. Our fieldwork included contacting Noridian, located in Fargo, North Dakota, 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;

⁴ Pursuant to the MMA, Noridian became a Medicare administrative contractor effective July 31, 2006, which was after our audit period.

- reviewed available CWF claim histories for the 415 claims with high-dollar payments to determine whether the claims had been canceled and 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 on the claims was correct and, if not, why the claims were incorrect;
- obtained documentation from the hospitals confirming all incorrect claims identified; and
- coordinated the calculation of overpayments and discussed the results of our review with Noridian.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the 415 high-dollar payments that Noridian made to hospitals for inpatient services for CYs 2003 through 2005, 306 were appropriate. The 109 remaining payments included net overpayments totaling \$3,030,671. At the start of our audit, hospitals had refunded overpayments totaling \$1,144,709 but had not refunded net overpayments totaling \$1,885,962.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units of service, reported incorrect procedure codes, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect incorrect payments.

FEDERAL REQUIREMENTS

Section 1815(a) of the Act prohibits Medicare payment for claims not supported by sufficient documentation. 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 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.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Noridian made 89 net overpayments totaling \$1,885,962, which hospitals had not refunded prior to the start of our audit.⁵ The overpayments involved hospital claims submitted with inaccurate data, including incorrect numbers of billing units of service, incorrect procedure codes, and excessive charges that resulted in inappropriate outlier payments.

The following examples illustrate the billing errors:

- One hospital billed 43,550 units of Healthcare Common Procedure Coding System code J7193 (Factor IX nonrecombinant) when it should have billed 436 units, resulting in an overpayment of \$310,817.
- One hospital billed outpatient drugs on three inpatient claims, resulting in a total overpayment of \$96,866.
- One hospital submitted four claims that covered intravenous therapy billed by the hour instead of by visit, resulting in a total overpayment of \$89,366.

The hospitals attributed most of the incorrect claims to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.

CAUSES OF INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Noridian made the incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect incorrect payments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of inappropriate payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any inappropriate payments.⁶

⁵ We could not determine the amount of the overpayment for 1 of the 89 claims. The provider indicated to us and to Noridian that it was willing to refund this overpayment. However, because of the time elapsed since the claim was initially filed, the adjustment will have to be manually processed. The provider said that it was waiting for assistance from Noridian to do so.

⁶ The fiscal intermediary sends a *Medicare Summary 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 Noridian:

- recover the \$1,885,962 in net overpayments,
- determine and recover the overpayment for the one inpatient claim still under adjudication,
- use the results of this audit in its provider education activities, and
- consider implementing controls to identify and review all payments greater than \$200,000 for inpatient services.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Noridian's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS



February 22, 2010

Patrick J. Cogley
Office of Inspector General
Region VII
601 East 12th Street
Room 0429
Kansas City, MO 64106

Paul O'Donnell
Vice President
Medicare Operations
900 42nd Street South
Fargo, ND 58103
701-277-2401
FAX: 701-277-5150
paul.odonnell@noridian.com

RE: Report Number A-07-09-04148

Dear Mr. Cogley:

Thank you for the opportunity to respond to the draft report of the U.S. Department of Health & Human Services, Office of Inspector General (OIG) dated February 3, 2010, entitled, *Review of High-Dollar Payments for Inpatient Services Processed by Noridian Administrative Services, LLC, for the Period January 1, 2003, Through December 31, 2005.*

We concur with the recommendation that all overpayments identified ought to be collected. Noridian Administrative Services, LLC, (NAS) has reviewed all claims identified as overpayments by this report. NAS has already collected these overpayments either by provider refund check or adjustment made by the provider.

The report references one inpatient claim that is currently being reviewed by the OIG, NAS and the provider. A determination has not been made on whether or not there is truly an overpayment on this claim. Inpatient claims are paid on a DRG rate and the provider wants to remove charges that would impact that rate. If the provider does not remove procedure or diagnosis codes, then no overpayment will exist. NAS and OIG will be working with the provider to determine the outcome of this claim.

As recommended, we will consider the results of this audit in the analysis of topics for provider education activity.

In order to review high dollar claims, an edit has been developed for the whole Part A standard system – Fiscal Intermediary Standard System (FISS). This edit will suspend claims payments at or over \$250,000 to verify information is correct, particularly the units billed. This standard edit is expected to be implemented on March 1, 2010.

Please advise if additional information is needed or if further clarification is needed on any of our responses.

Sincerely,

/s/ Paul O'Donnell

Paul O'Donnell
Vice President
Noridian Administrative Services, LLC