DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

JUN 27 2008

Report Number: A-04-07-07021

Mrs. Pamela Bell, Vice President
Blue Cross and Blue Shield of Georgia
3350 Peachtree Road, N.E.
Atlanta, Georgia 30326

Dear Mrs. Bell:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Excessive Payments for Outpatient and Inpatient Services Processed by Blue Cross and Blue Shield of Georgia." 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, it 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 Maritza Hawrey, Audit Manager, at (305) 536-5309 or through e-mail at Maritza.Hawrey@oig.hhs.gov. Please refer to report number A-04-07-07021 in all correspondence.

Sincerely,

Peter J. Barbera
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 EXCESSIVE PAYMENTS FOR OUTPATIENT AND INPATIENT SERVICES PROCESSED BY BLUE CROSS AND BLUE SHIELD OF GEORGIA

Daniel R. Levinson
Inspector General

June 2008
A-04-07-07021

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security 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), which administers the program, contracts with fiscal intermediaries (FI) to administer Medicare Part A and some Part B claims. FI responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying hospitals for services provided. Federal guidance requires FIs to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

To process hospitals' inpatient and outpatient claims, the FIs use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments when processing claims for prepayment validation.

Medicare guidance requires hospitals to bill services accurately by using proper Health Care Common Procedure Coding System (HCPCS) codes and by reporting units of service specifying the number of times that the provider performed the service or procedure.

In calendar years (CY) 2004 and 2005, FIs processed and paid 5,125 inpatient claims of $200,000 or more and 989 outpatient claims of $50,000 or more. We considered such payments to be high-dollar payments. Blue Cross and Blue Shield of Georgia, Inc. (BCBSG) is a Medicare Part A fiscal intermediary primarily serving Medicare hospitals in Georgia. BCBSG processed approximately 7.8 million claims during CYs 2004 and 2005. Of these 7.8 million claims, only 88 inpatient and 6 outpatient claims resulted in high-dollar payments.

OBJECTIVE

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

SUMMARY OF FINDINGS

Eighty-two of the 94 high-dollar payments that BCBSG made to hospitals for inpatient and outpatient services during CYs 2004 and 2005 were appropriate. The remaining 12 payments totaling $263,620 were inappropriate. Providers had refunded eight overpayments totaling $209,485 by the start of our fieldwork in June 2007. Four inappropriate payments totaling $54,135 remained outstanding.

BCBSG had edits in place for high-dollar charges during our audit period, which contributed to the high number of appropriate payments it processed. However, BCBSG made some inappropriate payments because neither its system nor the CWF had sufficient edits in place during CYs 2004 or 2005 to detect billing errors related to HCPCS codes and units of service.

RECOMMENDATION

We recommend that BCBSG recover the $54,135 in identified overpayments.

BLUE CROSS AND BLUE SHIELD OF GEORGIA COMMENTS

In written comments, BCBSG agreed with the findings and recommendation in our draft report. BCBSG has currently recovered $12,566 of the identified overpayments and is in the process of recovering the remaining $41,569. BCBSG's 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 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.

Fiscal Intermediary Responsibilities

CMS contracts with fiscal intermediaries (FI) to administer Medicare Part A and some Part B claims. FI responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to hospitals for services provided. Federal guidance provides that FIs maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

Claims for Inpatient and Outpatient Services

To process hospitals' inpatient and outpatient claims, the FIs use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments when processing claims for prepayment validation.

Medicare guidance requires hospitals to bill services accurately by using proper Healthcare Common Procedure Coding System (HCPCS) codes and by reporting units of service specifying the number of times that the provider performed the service or procedure.

In calendar years (CY) 2004 and 2005, FIs processed and paid 5,125 inpatient claims of $200,000 or more and 989 outpatient claims of $50,000 or more. We considered such payments to be high-dollar payments.

Blue Cross and Blue Shield of Georgia

Blue Cross and Blue Shield of Georgia, Inc.[1] (BCBSG) is a Medicare Part A fiscal intermediary serving hospitals in Georgia. During our audit period (CYs 2004 and 2005), BCBSG processed approximately 7.8 million claims. Of these 7.8 million claims, only 88 inpatient and 6 outpatient claims resulted in high-dollar payments.

[1]Georgia Medicare Part A is a division of the BlueCross and BlueShield of Georgia, Inc., an independent licensee of the BlueCross and BlueShield Association for the State of Georgia.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 88 inpatient and the 6 outpatient high-dollar claims BCBSG paid during CYs 2004 and 2005. We limited our review of BCBSG's internal control structure to those controls applicable to the 94 (88 inpatient claims and 6 outpatient claims) claims because our objective did not require an understanding of all internal controls over claims submission or claims processing. Our review allowed us to establish a reasonable assurance regarding 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 did not perform or request medical review on any of the 94 claims.

We conducted our fieldwork from June through October 2007 by working with BCBSG, located in Columbus, Georgia, and the Georgia hospitals that received high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;

- used CMS's National Claims History file to identify inpatient claims and outpatient claims with high-dollar Medicare payments;

- reviewed available CWF claims histories for high-dollar inpatient and outpatient claims to determine whether those claims had been canceled and superseded by a revised claim or whether the payments remained outstanding at the time of our fieldwork;

- analyzed claims that were reviewed by BCBSG to determine whether more information was needed from the hospitals;

- contacted the hospitals associated with the high-dollar payments to determine whether (1) the units of service shown on the claims were correct and, if not, why the claims were billed in error and (2) the hospitals agreed that a refund was appropriate; and

- validated with BCBSG that the claims were billed in error, 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.

FINDINGS AND RECOMMENDATION

Eighty-two of the 94 high-dollar payments that BCBSG made to hospitals for inpatient and outpatient services during CYs 2004 and 2005 were appropriate. The remaining 12 payments totaling $263,620 were inappropriate. Providers refunded eight of the overpayments totaling $209,485 prior to our fieldwork.

Distribution of Inpatient and Outpatient Claims

Claim Type	Appropriate	Inappropriate And Refunded	Overpayment (Underpayment)	Inappropriate And Not Refunded	Overpayment	Total
Inpatient	82	3	($76,990)	3	$1,089	88
Outpatient	0	5	$286,475	1	$53,046	6
Total	**82**	**8**	**$209,485**	**4**	**$54,135**	**94**

BCBSG had edits in place for high-dollar charges during our audit period, which contributed to the number of appropriate payments it processed. However, BCBSG made some inappropriate payments because neither its system nor the CWF had sufficient edits in place during CYs 2004 or 2005 to detect billing errors related to HCPCS codes and units of service.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the HCPCS. The Medicare "Hospital Manual," section 400 states: "Bill only for services provided. If your system initiates billing based on services ordered, you must confirm that the service has been provided before billing either the carrier or intermediary." Furthermore, section 462 states: "In order to be paid correctly and promptly, a bill must be completed accurately."

Also, 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 HIGH-DOLLAR PAYMENTS

BCBSG made 12 inappropriate payments (6 inpatient and 6 outpatient) totaling $263,620. As of June 2007, the start of our fieldwork, 8 of the 12 inappropriate payments totaling $209,485 had been refunded. Specifically:

- For five outpatient claims, BCBSG cumulatively overpaid hospitals $286,475 because the hospitals claimed incorrect units of service. The hospitals identified and refunded the overpayment prior to our fieldwork.

- For three inpatient claims, BCBSG cumulatively underpaid three hospitals $76,990. One hospital submitted a claim with incorrect dates of services, one hospital's claim was denied by the CWF, and one hospital's claim was affected by a CMS payment update.

The remaining four inappropriate payments, totaling $54,135 that hospitals had not refunded, occurred because providers incorrectly billed BCBSG for units of service. For example:

- One hospital billed 360 units of the drug Oxaliplatin for 36 units delivered. This error resulted in 324 excess units of service claimed and an overpayment of $53,046.

- One hospital billed 1,826 units of service on a claim that should have been billed as 1,779 units of service. This error resulted in 47 excess units of service claimed and an overpayment of $12,566.

- One hospital cumulatively billed 11,676 units of service on two claims that should have been billed as 11,702 units of service. This error resulted in a total of 26 units of service not claimed and a net underpayment of $11,477.

CAUSES OF OVERPAYMENTS

During CYs 2004 and 2005, BCBSG had a prepayment edit in place to suspend inpatient claims with reported charges exceeding $400,000 and outpatient claims with reported charges exceeding $70,000. For the suspended claims, BCBSG contacted providers to verify the appropriateness of the charges. Although BCBSG had prepayment edits in place to suspend claims, neither its system nor the CWF had sufficient edits in place in CYs 2004 or 2005 to detect billing errors related to HCPCS codes and units of services. Instead, CMS relied on providers to notify FIs of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[2]

[2]The FI sends a "Medicare Summary Notice" to the beneficiary after the provider files a claim for service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

On January 3, 2006, after the end of our audit period, CMS required FIs to implement a FI Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends outpatient claims that meet or exceed a reimbursement amount of $50,000 and requires intermediaries to contact hospitals to determine the legitimacy of the claims. CMS created this edit, in part, to identify and correct errors related to overstated units of service.

RECOMMENDATION

We recommend that BCBSG recover the $54,135 in identified overpayments.

BLUE CROSS AND BLUE SHIELD OF GEORGIA COMMENTS

In written comments, BCBSG agreed with the findings and recommendation in our draft report. BCBSG has currently recovered $12,566 of the identified overpayments and is in the process of recovering the remaining $41,569. BCBSG's comments are included in their entirety as the Appendix.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE PART A
INTERMEDIARY
Beneficiary Customer Service
1-800-MEDICARE (1-800-633-4227)
Provider Customer Service (877) 567-3095

May 27, 2008

Peter J. Barbera
Regional Inspector General for Audit Services
61 Forsyth Street S.W.
Suite 3T41
Atlanta, Georgia 30303

RE: Report Number A-04-07-07021

Dear Mr. Barbera,

We appreciate the opportunity to respond to your draft report entitled "Review of Excessive Payments for Outpatient and Inpatient Services Processed by Blue Cross and Blue Shield of Georgia."

We agree with the comments in the draft report, including the recommendation to recover $54,135 in identified overpayments. Currently, $12,566 has been recovered, and we are in the process of recovering the remaining amount of $41,569.

We would like to thank the OIG staff for the time and effort in conducting this audit. Our office maintains high standards for protecting the Medicare trust fund and, as your report states, we have implemented additional system edits to help prevent improper payments in the future.

If you have any questions, please contact Karen Duck at (706) 571-5351.

Sincerely,

Pamela F. Bell
by Karen Duck

Pamela F. Bell
Regional Vice President
Georgia Medicare
Blue Cross and Blue Shield of Georgia

Cc: Karen Duck, Manager, Performance Management, BCBSGA
Laurie Wright, Sr. Compliance Specialist, BCBSGA