DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

March 25, 2008

Report Number: A-06-07-00100

Mr. Jimmy Chaney
Director of Medical Claims
TriSpan Health Services
1064 Flynt Drive
Flowood, Mississippi 39232-9750

Dear Mr. Chaney:

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 Medicare Part A Outpatient Claims Processed by TriSpan Health Services for the Period January 1, 2003, Through December 31, 2003." 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, within 10 business days after the final report is issued, 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 Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-07-00100 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE PART A OUTPATIENT CLAIMS PROCESSED BY TRISPAN HEALTH SERVICES FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

March 2008
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Office of Inspector General

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

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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 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 to process and pay Medicare Part B claims submitted by hospital outpatient departments. 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.

Medicare guidance requires hospitals to bill accurately and to report units of service as the number of times that the service or procedure was performed.

TriSpan Health Services (TriSpan) is a Medicare Part A fiscal intermediary serving more than 1,800 Medicare providers in Mississippi, Louisiana, and Missouri. For calendar year (CY) 2003, TriSpan processed approximately 3.5 million outpatient claims, four of which resulted in payments of $50,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDINGS

All four of the high-dollar payments that TriSpan made for outpatient services for CY 2003 were not appropriate. The amount of the overpayment totaled $227,547. At the start of our fieldwork in April 2007:

- One of the payments was incorrect, and the hospital refunded the $51,935 overpayment.
- One of the payments was incorrect, and the hospital refunded the $52,586 overpayment identified during the audit.
- Two of the payments were incorrect, but the hospitals did not refund the $123,026 in overpayments because the claims had been suspended in the system.

Contrary to Federal guidance, the hospitals inappropriately overstated the units of service in each of the four high-dollar claims. TriSpan made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect billing errors related to units of service.

RECOMMENDATIONS

We recommend that TriSpan:

- inform us of the status of the recovery of the $123,026 in identified overpayments and
- use the results of this audit in its provider education activities.

TRISPAN'S COMMENTS

In its comments on our draft report, TriSpan agreed with our recommendations. The full text of TriSpan's comments is included as the Appendix.

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TRISPAN'S COMMENTS

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.

Medicare Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

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

In calendar year (CY) 2003, fiscal intermediaries processed and paid more than 131 million outpatient claims, 254 of which resulted in payments of $50,000 or more (high-dollar payments). We considered such claims to be at high risk for overpayment.

Claims for Outpatient Services

Hospitals generate the claims for outpatient services provided to Medicare beneficiaries. Medicare guidance requires hospitals to bill accurately and to report units of service as the number of times that the service or procedure was performed.

TriSpan Health Services

TriSpan Health Services (TriSpan) is a Medicare Part A intermediary serving more than 1,800 Medicare providers in Mississippi, Louisiana, and Missouri. For claims in CY 2003, TriSpan processed approximately 3.5 million outpatient claims, 4 of which resulted in high-dollar outpatient claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the four high-dollar payments for outpatient claims that TriSpan processed for CY 2003. We limited our review of TriSpan's internal controls to those applicable to the four 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 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.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare outpatient claims with high-dollar payments;
- reviewed available Common Working File claim 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;
- 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 and whether the hospitals agreed that refunds were appropriate; and
- coordinated our review with TriSpan.

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 objectives.

FINDINGS AND RECOMMENDATIONS

All four of the high-dollar payments that TriSpan made for outpatient services for CY 2003 were not appropriate. The amount of the overpayment totaled $227,547. At the start of our fieldwork in April 2007:

- One of the payments was incorrect, and the hospital refunded the $51,935 overpayment.
- One of the payments was incorrect, and the hospital refunded the $52,586 overpayment identified during the audit.

- Two of the payments were incorrect, but the hospitals did not refund the $123,026 in overpayments because the claims had been suspended in TriSpan's payment system.

Contrary to Federal guidance, the hospitals inappropriately overstated the units of service in each of the four high-dollar claims. TriSpan made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect billing errors related to units of service.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, Public Law No. 99-509, requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of this manual states: "In order to be processed 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 HIGH-DOLLAR PAYMENTS

TriSpan made four overpayments totaling $227,547 as a result of incorrect and excessive units of service billed by four hospitals.

- One hospital billed 810 units of service for 1 unit delivered. As a result, TriSpan paid the hospital $52,991 when it should have paid $1,056, an overpayment of $51,935. The hospital refunded the overpayment prior to our fieldwork.

- One hospital billed 30 units of service for 1 unit delivered. As a result, TriSpan paid the hospital $56,256 when it should have paid $3,670, an overpayment of $52,586. The hospital refunded the overpayment during our fieldwork.

- One hospital billed 216 units of service for 1 unit delivered. As a result, TriSpan paid the hospital $54,439 when it should have paid $2,344, an overpayment of $52,095. At the end of our fieldwork, the adjusted claim showed as suspended in the payment system. When TriSpan is able to reestablish in its system the claim that we reviewed, the adjusted claim will be processed.

- One hospital billed 667 units of service for 1 unit delivered. As a result, TriSpan paid the hospital $71,201 when it should have paid $270, an overpayment of $70,931. At the end of our fieldwork, the adjusted claim showed as suspended in TriSpan's payment system. When TriSpan is able to reestablish in its system the claim that we reviewed, the adjusted claim will be processed.

Four outpatient claims for CY 2003 contained overpayments totaling $227,547. As of the completion of our fieldwork, the hospitals had refunded two overpayments totaling $104,521. The remaining two claims, which accounted for $123,026 of the total overpayments, were processed by TriSpan but remained in suspension.

CAUSES OF OVERPAYMENTS

The hospitals agreed that overpayments had occurred and that refunds were due or had already been made. The hospitals attributed the incorrect claims to clerical errors or to their software edit programs, which did not detect and prevent incorrect billing of units of service.

In addition, during CY 2003, TriSpan did not have prepayment or postpayment controls to identify aberrant payments at the claim level, and the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments. In effect, CMS relied on hospitals to notify the intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[1]

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 high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

RECOMMENDATIONS

We recommend that TriSpan:

- inform us of the status of the recovery of the $123,026 in identified overpayments and
- use the results of this audit in its provider education activities.

TRISPAN'S COMMENTS

In its comments on our draft report, TriSpan agreed with our recommendations. TriSpan recovered $123,022 for the two identified overpayments. In response to the second recommendation, TriSpan said that it plans to publish frequently asked questions on its Web site to help providers understand the impact of billing excessive units and the importance of billing correctly. TriSpan also said that it plans to include the information in any applicable presentations or teleconferences it holds for providers.

The full text of TriSpan's comments is included as the Appendix.

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

APPENDIX

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1064 Flynt Drive • Flowood, MS • 39232-9570

February 4, 2008

Mr. Gordon L. Sato
Regional Inspector General for Audit Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Dear Mr. Sato:

This letter provides written comments from TriSpan Health Services, Inc. related to the Office of Inspector General (OIG) draft report number A-06-07-00100 entitled "Review of High-Dollar Payments for Medicare Part A Outpatient Claims Processed by TriSpan Health Services for the Period January 1, 2003, Through December 31, 2003."

For calendar year (CY) 2003, TriSpan processed approximately 3.5 million outpatient claims, four of which resulted in payments of $50,000 or more (high-dollar payments). The audit objective was to determine whether the high-dollar Medicare payments that TriSpan made to hospitals for outpatient services were appropriate. The OIG 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 and whether the hospitals agreed that refunds were appropriate.

All four of the high-dollar payments that TriSpan made for outpatient services for CY 2003 were not appropriate. The amount of the overpayment totaled $227,547. At the start of the OIG fieldwork in April 2007:

- One of the payments was incorrect, and the hospital refunded the $51,935 overpayment prior to the fieldwork.
- One of the payments was incorrect, and the hospital refunded the $52,586 overpayment identified during the audit.
- Two of the payments were incorrect, but the hospitals did not refund the $123,026 in overpayments because the adjustments had not yet been finalized for payment in the system.

Contrary to Federal guidance, the hospitals inappropriately overstated the units of service in each of the four high-dollar claims. TriSpan made the overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect billing errors related to units of service.

In the OIG draft report, there were two recommendations:

1) that TriSpan inform the OIG of the status of the recovery of the $123,026 in identified overpayments and
2) that TriSpan use the results of the audit in its provider education activities.

In response to the first recommendation:

- One hospital billed 216 units of service for 1 unit delivered. As a result, TriSpan paid the hospital $54,439 when it should have paid $2,344, an overpayment of $52,095. At the end of the OIG fieldwork, the adjusted claim showed as suspended in the payment system. Subsequently, this adjustment paid $2,347.70 and posted to the January 30, 2008, provider remittance advice. This resulted in a recovery of $52,091.30.

- One hospital billed 667 units of service for 1 unit delivered. As a result, TriSpan paid the hospital $71,201 when it should have paid $270, an overpayment of $70,931. At the end of the OIG fieldwork, the adjusted claim showed as suspended in the payment system. Subsequently, this adjustment paid $270.34 and posted to the January 9, 2008, provider remittance advice. This resulted in a recovery of $70,930.66.

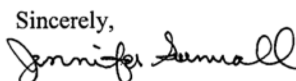
- The total recovery for the two claims was $123,021.96.

In response to the second recommendation, we plan to publish Frequently Asked Question(s) on our Web site to help our providers understand the impact of billing excessive units and to know the importance of billing correctly. We will also include this information in any applicable presentations or teleconferences held for our provider community during the fiscal year.

The standard system currently has edits in place to suspend high-dollar outpatient claims for review, and there are some local edits in place for excessive units for services identified through data analysis and Comprehensive Error Rate Testing (CERT) findings. TriSpan will continue to add local edits as needed and educate providers on proper billing of units of service.

If you have any questions or comments regarding this letter, please feel free to call me at (601) 664-4505.

Sincerely,



Jennifer Sumrall
Manager, Medicare Claims, Customer Service, Outreach and Education
TriSpan Health Services, Inc.