DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

December 17, 2007

Report Number: A-06-07-00090

Ms. Gerri Webb
Vice President
Government Programs
Chisholm Administrative Services
1215 South Boulder
Tulsa, Oklahoma 74119-2800

Dear Ms. Webb:

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 Oklahoma Medicare Part A Claims Processed by Chisholm Administrative 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 below.

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 this 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 direct them to the HHS action official. Please refer to report number A-06-07-00090 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Mr. Tom Lenz, Consortium Administrator
Consortium for Financial Management and Fee for Service Operations
CMS – Region 7
Richard Bolling Federal Building, Room 235
601 East 12th Street
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR OKLAHOMA MEDICARE PART A CLAIMS PROCESSED BY CHISHOLM ADMINISTRATIVE SERVICES FOR THE PERIOD JANUARY 1, 2003 THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

December 2007
A-06-07-00090

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

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer the Medicare Part A program. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying 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 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 (the 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.

To process providers' inpatient 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.

Chisholm Administrative Services (Chisholm) is a Medicare Part A fiscal intermediary serving Medicare providers in Oklahoma. Chisholm processed three calendar year 2003 inpatient claims that had payments of $200,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Chisholm's high-dollar Medicare payments to Part A providers for inpatient services were appropriate.

SUMMARY OF FINDING

The claim payments that Chisholm made to providers for inpatient services were appropriate. As a result, this report contains no recommendations.

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INTRODUCTION

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Fiscal Intermediary Responsibilities

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer the Medicare Part A program. 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 Services

Providers generate the claims for inpatient 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 (the 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 reports on its claim to estimate the cost of a case. Inaccurately reporting charges could lead to excessive outlier payments.

To process providers' inpatient 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 year (CY) 2003, providers submitted approximately 13.5 million inpatient claims nationwide. Of these 13.5 million claims, only 3,128 claims resulted in payments of $200,000 or more (high-dollar payments). We considered such claims to be at high risk for overpayment.

Federal Requirements

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 hospitals from incurring large

financial losses due to unusually expensive cases. Furthermore, the "Hospital Manual," section 462, states: "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."

Chisholm

Chisholm Administrative Services (Chisholm) is a Medicare Part A fiscal intermediary serving Medicare providers in Oklahoma. Chisholm processed 168,859 CY 2003 inpatient claims that had payments totaling more than $1 billion. Of these claims, Chisholm processed three claims that had high-dollar payments.

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 by Chisholm were hospitals; thus, the term "provider" as used in the remainder of this report refers to hospitals.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Chisholm's high-dollar Medicare payments to Part A providers for inpatient services were appropriate.

Scope

We reviewed the three high-dollar payments, totaling $662,639, processed during CY 2003. We limited our review of Chisholm's internal control structure to those controls applicable to the three 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 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 Part A inpatient 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;

- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly;

- reviewed itemized bills to determine whether the charges were appropriate; and

- coordinated our claim review with Chisholm.

We conducted our audit in accordance with generally accepted government auditing standards.

SUMMARY OF FINDING

The claim payments that Chisholm made to providers for inpatient services were appropriate. As a result, this report contains no recommendations.