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

DEC 15 2008

Report Number: A-04-08-00040

Ms. Lynda Northcutt, President
Cahaba Government Benefit Administrators, LLC
300 Corporate Parkway
Birmingham, Alabama 35242

Dear Ms. Northcutt:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Inpatient Claims Processed by Cahaba Government Benefit Administrators Fiscal Intermediary No. 00011 for the Period January 1, 2004, Through December 31, 2006." We will forward a copy of this report to the HHS action official 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 Eric Bowen, Audit Manager, at (404) 562-7789 or through e-mail at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-08-00040 in all correspondence.

Sincerely,

Peter J Barbera

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 HIGH-DOLLAR INPATIENT CLAIMS PROCESSED BY CAHABA GOVERNMENT BENEFIT ADMINISTRATORS FISCAL INTERMEDIARY NO. 00011 FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2006

Daniel R. Levinson
Inspector General

December 2008
A-04-08-00040

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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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

Pursuant to Title XVIII of the Social Security Act (the 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 A claims submitted by hospitals. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF 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 (DRG) 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 DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient services. Also, 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 2004 through 2006, Cahaba Government Benefit Administrators contractor No. 00011 (Cahaba GBA) was the fiscal intermediary in Iowa and processed 30 inpatient claims with payments of $200,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 30 high-dollar payments that Cahaba GBA made to Iowa hospitals for inpatient services during calendar years 2004 through 2006, 20 were appropriate. The remaining 10 payments included overpayments totaling $16,939 that had not been refunded prior to the start of our audit.

Contrary to Federal guidance, hospitals reported excessive units of service and charges that resulted in inappropriate payments. Generally, hospitals attributed the overpayments to incorrect claims data. Cahaba GBA made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments.

RECOMMENDATIONS

We recommend that Cahaba GBA:

- recover the $16,939 in identified overpayments,
- use the results of this audit in its provider education activities related to data entry procedures and proper documentation of charges, and
- consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.

AUDITEE COMMENTS

In written comments on the draft report, Cahaba GBA stated that it no longer had this workload and therefore could not act upon our recommendations. Cahaba GBA's comments are included in their entirety as Appendix A. Because Cahaba GBA could not act upon our recommendations, we forwarded the draft report to the new Medicare contractor, Wisconsin Physician Services (WPS). In written comments on the draft report, WPS acknowledged that it had assumed responsibility for the State of Iowa and associated Cahaba GBA processing activity earlier in 2008. WPS stated that it intended to recoup the overpaid amounts, use the results of the audit in future educational activities, and evaluate controls to determine whether additional controls are needed. WPS's comments are included in their entirety as Appendix B.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the 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 A claims submitted by hospitals. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Intermediaries use the Fiscal Intermediary Standard System (FISS) and CMS's Common Working File (CWF) to process hospitals' inpatient claims. The CWF can detect certain improper payments during prepayment validations.

In calendar years (CY) 2004 through 2006, fiscal intermediaries processed and paid approximately 40.7 million inpatient claims, 8,287 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 for inpatient hospital services. Under the prospective payment system, 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.[1] The Medicare fiscal intermediary identifies outlier cases by comparing the estimated costs of a case with a DRG-specific fixed-loss threshold.[2] To estimate the cost of a case, the fiscal intermediary uses the Medicare charges that the hospital reports on its claim and

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

[2]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.

the hospital-specific cost-to-charge ratio. Inaccurately reporting charges could lead to excessive outlier payments.

Cahaba Government Benefit Administrators

During our audit period (CYs 2004 through 2006), Cahaba Government Benefit Administrators contractor No. 00011 (Cahaba GBA) was the fiscal intermediary in Iowa. Cahaba GBA processed 30 inpatient claims during this period that resulted in high-dollar payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 30 high-dollar payments, which totaled approximately $11.3 million, for inpatient claims that Cahaba GBA processed during CYs 2004 through 2006. We limited our review of Cahaba GBA's internal controls to those applicable to the 30 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 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 our fieldwork from November 2007 through June 2008. Our fieldwork included contacting Cahaba GBA, located in Birmingham, Alabama, and the hospitals, located in Iowa, 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;

- reviewed available CWF claim histories for 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; and

- 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.

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

Of the 30 high-dollar payments that Cahaba GBA made to Iowa hospitals for inpatient services for CYs 2004 through 2006, 20 were appropriate. The remaining 10 payments included overpayments totaling $16,939 that had not been refunded prior to the start of our audit.

Contrary to Federal guidance, hospitals reported excessive units of service and charges that resulted in inappropriate payments. Generally, hospitals attributed the overpayments to incorrect claims data. Cahaba GBA made these incorrect payments because neither the FISS nor the CWF had sufficient edits in place to detect and prevent the overpayments.

FEDERAL REQUIREMENTS

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

Cahaba GBA made overpayments totaling $16,939 for 10 payments that hospitals had not refunded prior to the start of our audit. Hospitals received these overpayments by reporting excessive units of service and charges. The following examples illustrate the overpayments:

- A hospital submitted a claim for 12,347 units of service instead of 11,964 units of service. As a result of the 383 excess units of service claimed, Cahaba GBA overpaid the hospital approximately $11,954.

- A hospital submitted a claim that included 236 excess units of service. As a result, Cahaba GBA overpaid the hospital approximately $3,094.

- A hospital submitted three claims involving overstated Medicare charges. As a result, Cahaba GBA overpaid the hospital approximately $1,622.

- A hospital submitted five claims that lacked supporting documentation to justify the charges billed. As a result, Cahaba GBA overpaid the hospital approximately $269.

CAUSES OF OVERPAYMENTS

Generally, hospitals attributed the overpayments to incorrect claims data. In addition, Cahaba GBA made the incorrect payments because neither the FISS nor the CWF had sufficient edits in place to detect and prevent the overpayments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[3]

RECOMMENDATIONS

We recommend that Cahaba GBA:

- recover the $16,939 in identified overpayments,

- use the results of this audit in its provider education activities related to data entry procedures and proper documentation of charges, and

- consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.

AUDITEE COMMENTS

In written comments on the draft report, Cahaba GBA stated that it no longer had this workload and therefore could not act upon our recommendations. Cahaba GBA's comments are included in their entirety as Appendix A. Because Cahaba GBA could not act upon our recommendations, we forwarded the draft report to the new Medicare contractor, Wisconsin Physician Services (WPS). In written comments on the draft report, WPS acknowledged that it had assumed responsibility for the State of Iowa and associated Cahaba GBA processing activity earlier in 2008. WPS stated that it intended to recoup the overpaid amounts, use the results of the audit in future educational activities, and evaluate controls to determine whether additional controls are needed. WPS's comments are included in their entirety as Appendix B.

[3]The fiscal intermediary sends an "Explanation of Medicare Benefits" 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.

APPENDIXES

APPENDIX A

Lynda Northcutt
President
Cahaba Government Benefit Administrators, LLC

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC

September 5, 2008

Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Attention: Peter J. Barbera
Regional Inspector General for Audit Services
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

RE: Report Number: A-04-08-0040 Review of High-Dollar Inpatient Claims Processed by Cahaba Government Benefits Administrator Fiscal Intermediary No. 00011 for the Period January 1, 2004, Through December 31, 2006.

Dear Mr. Bowen:

We are in receipt of the captioned draft report. Cahaba Government Benefit Administrators®, LLC no longer has this workload and can not act upon the recovering the overpayments recommendation due to the MAC contract award of this workload to Wisconsin Physician Services (WPS). This workload was transitioned to WPS on May 1, 2008. We agree the recommendations regarding provider education and review of payments are reasonable. We await direction from the Centers for Medicare and Medicaid Services before we act on the recommendations.

If you should have any questions regarding this report, please contact Molly Echols, Manager Risk and Compliance at (205) 220-1587 or via email at Mechols@cahabagba.com.

Sincerely,

Lynda Northcutt
President
Cahaba Government Benefit Administrators®, LLC

LN/jm

CC: Brandon Ward, Vice President, Cahaba GBA
David Brown, Director, Cahaba GBA Administration
Jim Hill, Divisional Manager, Cahaba GBA

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

November 21, 2008

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

Re: OIG Blue Book Audit A-04-08-00040 - August 2008

Dear Mr. Barbera:

This letter is in response to the Draft OIG Blue Book titled "Review of High Dollar Inpatient Claims Processed by Cahaba Government Benefit Administrators Fiscal Intermediary No. 00011 for the Period January 1, 2004, Through December 31, 2006." The letter, addressed to Lynda Northcutt, Cahaba Government Benefit Administrators (GBA) LLC, dated August 22, 2008, was received in our office on November 7. In your letter, you requested that comments be provided on each of the recommendations.

WPS assumed responsibility for the state of Iowa and associated Cahaba GBA's processing activity earlier in 2008. The OIG reviewed 30 high-dollar inpatient claims, of which 20 were appropriate. The results of their review indicated that the remaining ten payments included overpayments totaling $16,939.

OIG Recommendations:

- *recover the $16,939 in overpayments,*
- *use the results of this audit in its provider education activities related to data entry procedures and proper documentation of charges, and*
- *consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.*

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

The results of this review have been shared with the WPS Provider Outreach area so that they can be incorporated into future educational activities. WPS staff will use the results of this audit, where applicable, in our future education activities.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

WPS will evaluate current controls to determine if additional ones are needed. The WPS Reimbursement and Claims Departments currently monitors out-going checks for abnormalities in payment tolerance level. Payments outside the tolerance level for a provider are investigated to determine their validity. If applicable, payments are suspended pending further investigation.

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

Sincerely,

Mark DeFoil
Director, Contract Coordination

cc: Eric Bowen, OIG
Nitza Correa, CMS
Suzanne Johnson, CMS