DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

DEC - 8 2008

TO: Kerry Weems
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 First Coast Service Options, Inc., for the Period January 1, 2004, Through December 31, 2005 (A-04-07-06020)

Attached is an advance copy of our final report on high-dollar payments for inpatient services processed by First Coast Service Options, Inc. (First Coast), for the period January 1, 2004, through December 31, 2005. These claims were submitted by providers in Florida. We will issue this report to First Coast within 5 business days. This audit was part of a nationwide review of excessive payments for inpatient services of $200,000 or more (high-dollar payments).

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

Of the 199 high-dollar payments that First Coast made to hospitals for inpatient services for calendar years 2004 and 2005, 74 were appropriate. The remaining 125 payments included overpayments totaling $1,651,968, which had not been repaid by the start of our audit. Contrary to Federal guidance, hospitals reported units of service inaccurately and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to clerical errors, conversion of the pharmacy system from dispensing units to billing units, or outdated billing systems. First Coast made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place to detect and prevent the overpayments.

We recommend that First Coast recover the $1,651,968 in identified overpayments, 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.

In written comments on our draft report, First Coast agreed to initiate recovery procedures for the overpayments that we identified. First Coast stated that it was redesigning its education

materials to strengthen their effectiveness and that it would work with the Centers for Medicare & Medicaid Services to implement an edit for payments greater than $200,000.

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 e-mail at George.Reeb@oig.hhs.gov or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through e-mail at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-07-06020.

Attachment

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 11 2008

Report Number: A-04-07-06020

Ms. Sandy Coston
President
First Coast Service Options, Inc.
532 Riverside Avenue, 20 T
Jacksonville, Florida 32202

Dear Ms. Coston:

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 Inpatient Services Processed by First Coast Service Options, Inc., for the Period January 1, 2004, 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.

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 Mary Ann Moreno, Audit Manager, at (404) 562-7770 or through e-mail at Mary.Moreno@oig.hhs.gov. Please refer to report number A-04-07-06020 in all correspondence.

Sincerely,

Peter J. Barbera

Peter J. Barbera
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, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR INPATIENT SERVICES PROCESSED BY FIRST COAST SERVICE OPTIONS, INC., FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

December 2008
A-04-07-06020

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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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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The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

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THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

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 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 2004 and 2005, First Coast Service Options, Inc. (First Coast), was the fiscal intermediary in Florida. First Coast processed approximately 1.6 million inpatient claims during this period, 199 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 First Coast made to hospitals for inpatient services were appropriate.

SUMMARY OF FINDING

Of the 199 high-dollar payments that First Coast made to hospitals for inpatient services for calendar years 2004 and 2005, 74 were appropriate. The remaining 125 payments included overpayments totaling $1,651,968, which had not been repaid by the start of our audit.

Contrary to Federal guidance, hospitals reported units of service inaccurately and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to clerical errors, conversion of the pharmacy system from dispensing units to billing units, or outdated billing systems. First Coast 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 First Coast:

- recover the $1,651,968 in identified overpayments,
- 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.

FIRST COAST SERVICE OPTIONS COMMENTS

In written comments on our draft report, First Coast agreed to initiate recovery procedures for the overpayments that we identified. First Coast stated that it was redesigning its education materials to strengthen their effectiveness and that it would work with CMS to implement an edit for payments greater than $200,000. The complete text of First Coast's comments is included as the Appendix.

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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 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 and 2005, fiscal intermediaries processed and paid approximately 27 million inpatient claims, 5,125 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 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 the hospital-specific cost-to-charge ratio. Inaccurately reporting charges could lead to excessive outlier payments.

[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.

First Coast Service Options, Inc.

During our audit period (CYs 2004 and 2005), First Coast Service Options, Inc. (First Coast), was the fiscal intermediary in Florida. First Coast processed approximately 1.6 million inpatient claims during this period, 199 of which resulted in high-dollar payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 199 high-dollar payments, which totaled $56,867,792, for inpatient claims that First Coast processed during CYs 2004 and 2005. We limited our review of First Coast's internal controls to those controls applicable to the 199 high-dollar 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 performed our fieldwork from April 2007 through May 2008. Our fieldwork included contacting First Coast, located in Jacksonville, Florida, and the hospitals that received 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;
- 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
- validated with First Coast that partial 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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the 199 high-dollar payments that First Coast made to hospitals for inpatient services for CYs 2004 and 2005, 74 were appropriate. The remaining 125 payments included overpayments totaling $1,651,968, which had not been repaid by the start of our audit.

Contrary to Federal guidance, hospitals reported units of service inaccurately and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to clerical errors, conversion of the pharmacy system from dispensing units to billing units, or outdated billing systems. First Coast 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.

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

First Coast made overpayments totaling $1,651,968 for 125 payments, which hospitals had not refunded prior to the start of our audit. Hospitals received these overpayments by reporting excessive units of service and excessive charges that resulted in inappropriate outlier payments. The following examples illustrate the high-dollar overpayments:

- A hospital billed 323 excessive units of service because it did not document some of the units in the medical records, did not credit unused medication back to the patient's account, and made a clerical error. As a result, First Coast paid the hospital $202,147 when it should have paid $189,968, a $12,179 overpayment.

- A hospital billed 199 excessive units of service because of a pharmacy computer system conversion error. As a result, First Coast paid the hospital $344,722 when it should have paid $67,553, an overpayment of $277,169.

CAUSES OF OVERPAYMENTS

Hospitals attributed most of the incorrect claims to clerical errors, conversion of the pharmacy system from dispensing units to billing units, or outdated billing systems. First Coast made the incorrect payments because neither the Fiscal Intermediary Standard System 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 First Coast:

- recover the $1,651,968 in identified overpayments,
- 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.

FIRST COAST SERVICE OPTIONS COMMENTS

In its October 8, 2008, written comments on our draft report, First Coast agreed to initiate recovery procedures for the overpayments that we identified. First Coast stated that it was redesigning its education materials to strengthen their effectiveness and that it would work with CMS to implement an edit for payments greater than $200,000. The complete text of First Coast's comments is included as the Appendix.

[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.

APPENDIX

FIRST COAST
SERVICE OPTIONS, INC.
WHEN EXPERIENCE COUNTS & QUALITY MATTERS

Sandy Coston
CEO & President
First Coast Service Options, Inc.
Sandy.Coston@fcso.com

October 8, 2008

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

Reference: A-04-07-06020

Dear Mr. Barbera:

We received the U.S. Department of Health & Human Services, Office of Inspector General draft report entitled, "Review of High-Dollar Payments for Inpatient Services Processed by First Coast Service Options, Inc" (FCSO) for the period January 1, 2004 through December 31, 2005. We appreciate the opportunity to review and provide comments prior to release of the final report.

In the draft report, you recommended:

Recommendation 1:

- Recover the $1,651,968 in identified overpayments.

  Response:
  FCSO will initiate its standard overpayment recovery procedures to recover the overpayment identified by the OIG.

532 Riverside Avenue, Jacksonville, Florida 32202
P.O. Box 45274, Jacksonville, Florida 32234-5274
Tel: 904-791-8409
Fax: 904-361-0372
www.fcso.com

Recommendation 2:

- Use the results of this audit in its provider education activities, and

  Response:
  Educational materials are being redesigned to strengthen their effectiveness with providers. FCSO will update our website and provider outreach publications.

Recommendation 3:

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

  Response:
  FCSO concurs with the recommendation for a FISS edit that would suspend an inpatient claim resulting in payment greater than $200,000. However, the FISS shared system has limitations in claim editing capability. Editing based on reimbursement dollars can only be accomplished through a hard-coded system edit. FCSO will work through the existing process to elevate this edit issue to CMS for consideration in future system changes.

Again, we appreciate the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding our response, please contact Mr. Gregory W. England at (904) 791-8364.

Sincerely,

Sandy Coston

Sandy Coston

cc: Greg England