



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office Of Inspector General
Office Of Audit Services

July 24, 2008

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Report Number: A-02-08-01002

Ms. Sandra Miller
President
National Government Services
8115 Knue Road
Indianapolis, Indiana 46250

Dear Ms. Miller:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Medicare Payments to Hospitals for Inpatient Claims Processed by National Government Services for the Period January 1, 2003, 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 Brenda Ryan, Audit Manager, at (212) 264-4677 or through e-mail at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-08-01002 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "James P. Edert".

James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nan Foster Reilly, Acting 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
MEDICARE PAYMENTS TO
HOSPITALS FOR
INPATIENT CLAIMS PROCESSED
BY NATIONAL GOVERNMENT
SERVICES FOR THE PERIOD
JANUARY 1, 2003, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

July 2008
A-02-08-01002

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:

Office of Audit Services

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.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

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.

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR
MEDICARE PAYMENTS TO
HOSPITALS FOR
INPATIENT CLAIMS PROCESSED
BY NATIONAL GOVERNMENT
SERVICES FOR THE PERIOD
JANUARY 1, 2003, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

July 2008
A-02-08-01002

Notices

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 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 (intermediaries) to process and pay Medicare Part A (inpatient) claims submitted by providers.

Providers generate the claims for inpatient services provided to Medicare beneficiaries. CMS guidance requires that providers bill accurately for the services provided and enter the appropriate revenue codes to identify specific accommodation and ancillary charges billed. Inpatient hospital services are paid based on the Medicare prospective payment system (PPS). Under the PPS, hospitals are paid a predetermined amount for a claim based on a patient's placement into a specific diagnosis-related group (DRG) and an additional amount, known as an outlier, for stays that have extraordinary high costs. In addition, a provider is liable for overpayment on a claim if it is unable to submit documentation to substantiate that it performed the services billed.

To process providers' inpatient claims, intermediaries use the Fiscal Intermediary Standard System, as well as CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

National Government Services (formerly Empire Medicare Services) is the Medicare intermediary for over 500 hospitals in Connecticut, Delaware, and New York. During calendar years (CY) 2003–2005, National Government Services processed more than 3 million hospital inpatient claims, 1,444 of which resulted in payments of \$200,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether National Government Services' high-dollar Medicare payments to hospitals for inpatient services were appropriate.

SUMMARY OF FINDING

Of the 100 high-dollar payments in our statistical sample that National Government Services made to providers, 82 payments were appropriate. However, National Government Services overpaid providers \$463,694 for the remaining 18 payments. Providers refunded five overpayments, totaling \$65,827, prior to our fieldwork. At the start of our fieldwork, 13 of the overpayments, totaling \$397,867, remained outstanding.

National Government Services made the overpayments because hospitals claimed incorrect units of service for 14 claims and did not have sufficient documentation supporting the services billed

for 4 claims. In addition, the Medicare claims processing systems did not have sufficient edits in place during CYs 2003–2005 to detect and prevent payments for these types of erroneous claims.

Based on the sample results, for our 3-year audit period, we estimate that National Government Services made 260 overpayments, totaling \$6,695,738, to hospitals for inpatient services.

RECOMMENDATIONS

We recommend that National Government Services:

- inform us of the status of the recovery of the \$463,694 in overpayments that our audit identified,
- review the remaining 1,344 high-dollar claims processed during CYs 2003–2005 with potential overpayments estimated at \$6,232,044 (\$6,695,738 less \$463,694) and work with the providers that claimed these services to recover any overpayments,
- consider identifying and recovering any additional overpayments made for high-dollar inpatient claims paid after CY 2005, and
- use the results of this audit in its provider education activities.

NATIONAL GOVERNMENT SERVICES COMMENTS

In its July 18, 2008, comments on the draft report, National Government Services agreed with our recommendations. National Government Services' comments appear in their entirety in Appendix C.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Fiscal Intermediaries	1
Claims for Inpatient Services	1
National Government Services	2
Fiscal Intermediary Edits	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	3
FINDING AND RECOMMENDATIONS	3
MEDICARE REQUIREMENTS	4
INAPPROPRIATE HIGH-DOLLAR PAYMENTS	4
RECOMMENDATIONS	5
NATIONAL GOVERNMENT SERVICES COMMENTS	6
APPENDIXES	
A – SAMPLE DESIGN AND METHODOLOGY	
B – SAMPLE RESULTS AND ESTIMATES	
C – NATIONAL GOVERNMENT SERVICES COMMENTS	

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

Prior to October 1, 2005, Section 1816(a) of the Act (42 U.S.C § 1395h) authorized CMS to contract with fiscal intermediaries (intermediaries) to process and pay Medicare Part A (inpatient) claims submitted by providers.¹ Federal regulations (42 CFR § 421.100) state that 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. CMS guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for Inpatient Services

Claims for inpatient services originate at the providers. Section 1861(u) of the Act (42 U.S.C § 1395x) defines providers as hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, and hospice programs. However, our audit was limited to claims submitted by hospitals; thus, the term "provider" as used throughout this report refers to hospitals.

Providers generate the claims for inpatient services provided to Medicare beneficiaries. CMS guidance requires that providers bill accurately for the services provided and enter the appropriate revenue codes to identify specific accommodation and ancillary charges billed. Inpatient hospital services are paid based on the Medicare prospective payment system (PPS). Under the PPS, hospitals are paid a predetermined amount for a claim based on a patient's placement into a specific diagnosis-related group (DRG) and an additional amount, known as an outlier, for stays that have extraordinary high costs. In addition, a provider is liable for overpayment on a claim if it is unable to submit documentation to substantiate that it performed the services billed.

To process providers' inpatient claims, intermediaries use the Fiscal Intermediary Standard System, as well as CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

During calendar years (CY) 2003–2005, providers nationwide submitted more than

¹The Medicare Modernization Act of 2003, Pub. L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1816(a), to require that Medicare administrative contractors replace carriers and intermediaries by October 2011.

40 million inpatient hospital claims to intermediaries. Of these, 8,253 claims resulted in payments of \$200,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

National Government Services

National Government Services (formerly Empire Medicare Services) is the Medicare intermediary for over 500 hospitals in Connecticut, Delaware, and New York. During CYs 2003–2005, National Government Services processed more than 3 million hospital inpatient claims, 1,444 of which resulted in payments of \$200,000 or more.

In January 2007, Empire Medicare Services was one of five companies combined to become National Government Services.² The name “National Government Services” used throughout this report refers to the intermediary formerly known as Empire Medicare Services.

Fiscal Intermediary Edits

In January 2007, after our audit period, CMS required intermediaries to implement units-of-service edits referred to as “medically unlikely edits.” These edits are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the “Medicare Program Integrity Manual,” Publication 100-08, Transmittal 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, HCPCS code, date of service, and billing provider against a specified number of units of service. Intermediaries must return to providers, claims with units of service that exceed the specified number.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether National Government Services’ high-dollar Medicare payments to hospitals for inpatient services were appropriate.

Scope

We reviewed a statistical sample of 100 high-dollar payments, totaling \$24,521,989, from the 1,444 high-dollar payments, totaling \$370,371,055, that National Government Services processed during CYs 2003–2005.

We limited our review of National Government Services’ internal controls to those applicable to the 100 sampled 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.

²AdminaStar Federal; Anthem Health Plans of New Hampshire, Inc.; Associated Hospital Service; Empire Medicare Services; and United Government Services, LLC combined operations and became National Government Services.

We performed our fieldwork from August 2007 to June 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify a sampling frame of 1,444 Medicare inpatient claims with high-dollar payments processed by National Government Services during CYs 2003–2005;
- selected a simple random sample of 100 payments from the population of 1,444 high-dollar payments processed by National Government Services during CYs 2003–2005, as detailed in Appendix A;
- reviewed available Common Working File claims histories for each of the 100 sample items to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly for our 100 sample claims;
- coordinated our claim review, including the calculation of any overpayments, with National Government Services; and
- estimated the number and dollar impact of the overpayments in the total population of 1,444 high-dollar payments.

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 finding and conclusions based on our audit objective. 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 100 high-dollar payments in our statistical sample that National Government Services made to providers, 82 payments were appropriate. However, National Government Services overpaid providers \$463,694 for the remaining 18 payments. Providers refunded five overpayments, totaling \$65,827, prior to our fieldwork. At the start of our fieldwork, 13 of the overpayments, totaling \$397,867, remained outstanding.

National Government Services made the overpayments because hospitals claimed incorrect units of service for 14 claims and did not have sufficient documentation supporting the services billed for 4 claims. In addition, the Medicare claims processing systems did not have sufficient edits in place during CYs 2003–2005 to detect and prevent payments for these types of erroneous claims.

Based on the sample results, for our 3-year audit period, we estimate that National Government Services made 260 overpayments, totaling \$6,695,738, to hospitals for inpatient services.

MEDICARE REQUIREMENTS

Section 3700 of CMS’s “Medicare Intermediary Manual,” requires that intermediaries maintain adequate internal controls over data processing systems to preclude increased program costs and erroneous or delayed payments.

Pursuant to section 462 of CMS’s “Hospital Manual,” in order to be paid correctly and promptly, a bill must be completed accurately. Further, chapter 3, section 10 of CMS’s “Medicare Claims Processing Manual,” requires that providers bill only for services provided and submit all information necessary to support claims for those services. In addition, chapter 25, section 75.4 of the “Medicare Claims Processing Manual” requires that providers enter the appropriate revenue codes to identify specific accommodation and ancillary charges billed.

Pursuant to section 3708.2(G) of the “Medicare Intermediary Manual,” the provider is liable for overpayment on claims if it does not submit documentation to substantiate that it performed the services billed.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

For 14 overpayments totaling \$417,731, providers billed for excessive units of service. The following examples illustrate inappropriate units-of-service payments:

- A provider billed 11,768 units of a respiratory service (handheld nebulizer treatment) for 1,721 units delivered. The provider stated that it had entered the incorrect number of treatments delivered. As a result, National Government Services paid the provider \$430,539 when it should have paid \$264,713, an overpayment of \$165,826. The provider refunded the overpayment during our fieldwork.
- A provider billed excessive units of service for 15 of the revenue center codes on a claim. The provider stated that it had entered incorrect units for pharmacy, intravenous therapy, medical/surgical supplies, minor surgery, blood administration, ultrasound services, respiratory services, and gastrointestinal services. As a result, National Government Services paid the provider \$314,945 when it should have paid \$298,848, an overpayment of \$16,097. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

For the remaining four overpayments totaling \$45,963, providers did not have sufficient documentation in the patient’s records supporting the services billed. The following example

illustrates a payment for which the provider did not have the required documentation supporting the services billed:

- The provider billed units of service under 14 revenue center codes (pharmacy, intravenous therapy, medical/surgical supplies, laboratory services, radiological services, rehabilitation services, pulmonary function, and cardiology procedures) for which the provider stated that it did not have documentation in the patient records to support all services billed. As a result, National Government Services paid the provider \$227,655 when it should have paid \$211,185, an overpayment of \$16,470. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

Providers attributed the incorrect claims to clerical errors made by their billing staff and technical issues when submitting claims. In addition, during CYs 2003–2005, the Fiscal Intermediary Standard System and the CMS Common Working File did not have sufficient edits in place to detect and prevent payments for these types of erroneous claims. Instead, CMS relied on providers to notify intermediaries of overpayments and on beneficiaries to review their “Medicare Summary Notice”³ and disclose any provider overpayments.

RECOMMENDATIONS

We recommend that National Government Services:

- inform us of the status of the recovery of the \$463,694 in overpayments that our audit identified,
- review the remaining 1,344 high-dollar claims processed during CYs 2003–2005 with potential overpayments estimated at \$6,232,044 (\$6,695,738 less \$463,694) and work with the providers that claimed these services to recover any overpayments,
- consider identifying and recovering any additional overpayments made for high-dollar inpatient claims paid after CY 2005, and
- use the results of this audit in its provider education activities.

³The intermediary sends a “Medicare Summary Notice” to the beneficiary after the provider files a claim for Medicare service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

NATIONAL GOVERNMENT SERVICES COMMENTS

In its July 18, 2008, comments on the draft report, National Government Services agreed with our recommendations. National Government Services' comments appear in their entirety in Appendix C.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether National Government Services' high-dollar Medicare payments (\$200,000 or more) to hospitals for inpatient services were appropriate.

POPULATION

The population was all hospital inpatient claims with service dates in calendar years 2003 through 2005 for which National Government Services paid providers \$200,000 or more.

SAMPLING FRAME

The sampling frame was an Access file containing 1,444 hospital inpatient claims with service dates in calendar years 2003 through 2005 for which National Government Services paid a provider \$200,000 or more. The total reimbursement for the 1,444 claims was \$370,371,055. The paid claims data was extracted from the Centers for Medicare & Medicaid Services National Claims History File.

SAMPLE UNIT

The sample unit was an inpatient claim paid to a provider for services rendered to a Medicare beneficiary during the audit period. One claim may contain multiple lines of service.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample size of 100 high-dollar hospital inpatient claims.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Inspector General, Office of Audit Services Statistical Sampling software, RAT-STATS 2007 version 1. We used the random number generator for our simple random sample.

METHOD FOR SELECTING SAMPLE ITEMS

We sequentially numbered the claims in our sampling frame and selected the corresponding frame items that correlated to the random numbers. We then created a list of 100 sample items.

CHARACTERISTICS TO BE MEASURED

We based our determination of whether each sampled high-dollar payment was appropriate on Federal regulations and guidance. Specifically, if at least one of the following characteristics was met, we considered the payment under review inappropriate:

- The provider indicated that the Diagnosis Related Group on the claim was misstated.
- The number of units of service was incorrectly billed (outlier claims).
- The provider indicated that the procedure billed was not performed or that the procedure or revenue code billed did not accurately represent the service(s) rendered (outlier claims).
- The provider indicated that the amount billed for the procedure or service exceeded amounts on the hospital's charge description schedule (outlier claims).

ESTIMATION METHODOLOGY

We used RAT-STATS to calculate our estimates. We estimated the total number of high-dollar payments that were inappropriate and the dollar impact of the inappropriate payments.

SAMPLE RESULTS AND ESTIMATES

The results of our review of the 100 high-dollar inpatient payments were as follows:

Sample Details and Results

No. of Payments in Frame	Value of Frame	Sample Size	Value of Sample Payments	No. of Overpayments	Value of Overpayments
1,444	\$370,371,055	100	\$24,521,989	18	\$463,694

Estimates

(Limits Calculated for a 90-Percent Confidence Interval)

	<u>Estimated No. of Inappropriate High-Dollar Payments</u>	<u>Estimated Dollar Value of Inappropriate High-Dollar Payments</u>
Point Estimate	260	\$6,695,738
Lower Limit	176	\$2,014,035
Upper Limit	364	\$11,377,442



8115 Knue Road
Indianapolis, Indiana 46250-1936
www.NGSMedicare.com

A CMS Contracted Agent

Medicare

July 18, 2008

Mr. James P. Edert
Regional Inspector General for Audit Services
Office of Inspector General, Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Re: Response to Draft Report Number A-02-08-01002

Dear Mr. Edert:

This letter is in response to the above referenced draft report entitled "Review of High-Dollar Payments to Hospitals for Inpatient Claims Processed by National Government Services for the Period January 1, 2003 through December 31, 2005."

National Government Services (NGS) agrees with the audit recommendations noted in the draft report and offer the following comments.

1. The review of the \$463,694 in overpayments identified is being reviewed and recovery actions will be initiated as needed.
2. NGS will contact the providers identified within the remaining 1,344 claims and request that self audits be performed for services billed and adjust any claims where a billing error occurred.
3. NGS will also identify high-dollar claims processed after CY 2005 and contact the associated providers and request that a self audit be performed and submit corrected bills, if appropriate.
4. The information identified in all these reviews will be shared with our Provider Outreach and Education Department to ensure providers are aware of correct billing procedures.

NGS appreciates the opportunity to respond to the draft report. Should you have further questions, please feel free to contact Cheryle Giamartino, Claims Manager, at 315-442-4704.

Sincerely,

A handwritten signature in black ink that reads "David Crowley".

David Crowley
Staff Vice President
Claims Management

cc: Sarah Litteral, Part A/RHHI Claims Director
Cheryle Giamartino, Claims Manager

