Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE 2002 FINANCIAL STATEMENT ACTIVITY AT MUTUAL OF OMAHA

JANET REHNQUIST
INSPECTOR GENERAL

OCTOBER 2002
A-07-02-04002

Office of Inspector General

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

October 7, 2002

Common Identification Number A-07-02-04002

Mr. Rick Reeves
Vice President & Director, Medicare
Mutual of Omaha Insurance Company
Mutual of Omaha Plaza (LL-2)
Omaha, Nebraska 68175

Dear Mr. Reeves:

This final report provides you with the results of our audit work related to the Medicare 2002 financial statement activity at Mutual of Omaha (Mutual). The objectives of our audit were to determine whether Medicare fee-for-service claims were: furnished by certified Medicare providers to eligible beneficiaries; reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records. The period of this audit was the quarter of January 2002 through March 2002.

Our review of 151 claims totaling $530,367 of Medicare payments disclosed that 25 claims did not comply with Medicare laws and regulations. The 25 claims had 133 line errors representing $12,070 in improper payments and one underpayment of $7,016. All of these improper payments were detected by medical reviews coordinated by the Office of Inspector General (OIG). When these claims were originally submitted to Mutual, they contained no visible errors.

BACKGROUND

This audit was performed in conjunction with the financial statement audit required by the Chief Financial Officer Act of 1990, as amended. The results of this review will be combined with the results at other Medicare contractors to establish a nationwide payment error rate. The OIG will prepare a consolidated report of the nationwide results of the Medicare contractors' reviews. That report will be provided to the independent accounting firm of Ernst & Young L.L.P. for their use in rendering an audit opinion on the Centers for Medicare and Medicaid Services' (CMS) Financial Statements for 2002.

The CMS administers the Medicare program by contracting with private organizations to pay and process Medicare claims. The CMS has contracted with Mutual as a fiscal intermediary (FI) to process and pay Part A claims for hospitals and other medical providers.

With respect to financial reporting, FI's prepare CMS Form 1521 (Contractor Draws on Letter of Credit) and CMS Form 1522 (Monthly Contractor Financial Report) each month to reconcile Medicare's benefit payments per the contractor's bank to CMS and contractor records. The CMS Form 1521 summarizes the vouchers the banks submit to the Federal Reserve to request transfers of funds to the contractor's bank account. The amounts drawn by the bank for benefit payments are reported on the CMS Form 1521 as *Voucher Total* and these draws are included on the CMS Form 1522 as *Total Funds Drawn.*

The CMS Form 1522 reports all "Paid Claims" and "Non-Claims Transactions" for the month to CMS. The "Non-Claims Transactions" represent items such as cost report settlements, periodic interim payments, and cash collections. The net "Paid Claims" and "Non-Claims Transactions" in a given month account for the "*Total Funds Expended*" on the CMS Form 1522. The *Total Funds Expended* also represents the sum of all checks and electronic funds transfer payments issued during the calendar month, less voided checks and overpayment recoveries.

For the months of January through March 2002, *Total Funds Expended* on the CMS Forms 1522 prepared by Mutual totaled $5.50 billion and *Total Funds Drawn* on the CMS Forms 1522 prepared by Mutual totaled $5.44 billion.

Objectives, Scope, and Methodology

The objectives of our audit were to determine whether Medicare fee-for-service claims were: furnished by certified Medicare providers to eligible beneficiaries; reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

We reviewed the contractor's reconciliation of its paid claims tapes, total funds expended, and funds drawn for each of the monthly CMS 1521 and 1522 Forms in the January through March 2002 quarter. After verifying the reconciliation, for each month of the quarter, we selected a random sample of 50 beneficiaries from the quarter stratified into 4 strata determined by total amounts of payments for services per beneficiary. The FI processed 151 Medicare claims for the 50 sample beneficiaries during the quarter.

To determine whether payments were in error, the claims were reviewed to verify that the payment was for a covered service furnished to an eligible beneficiary by an eligible provider in accordance with Medicare laws and regulations; the claim was coded, priced, and paid correctly; and the paid claim was accurately recorded and reported by the contractors and CMS to its general ledger.

Specifically, 15 peer review organizations (PRO) reviewed the medical records for the inpatient claims. The remainder of the medical records was reviewed by the FI medical reviewers to determine whether the services were covered by Medicare and the coding was correct. To determine whether services were furnished to eligible beneficiaries, by an eligible provider; we reviewed the Social Security Administration's beneficiary eligibility records for the 50 beneficiaries and the CMS provider eligibility files as well as the OIG's excluded provider list for all of the 58 providers in our sample of 151 claims. For each of the claims, we also verified that Medicare was the primary payer and that the payment was not a duplicate. To determine if the claim was priced correctly, we independently priced 11 claims for 5 beneficiaries. To determine if the claim was paid correctly, accurately recorded and reported by the contractor to CMS, we verified that all services were subjected to applicable deductible and co-insurance amounts. In addition, the paid claims tapes were reconciled to the total funds expended reported on the CMS Forms 1522.

Our audit was performed in accordance with generally accepted government auditing standards. Our tests of internal controls were generally limited to Mutual of Omaha's process of reconciling total funds expended reported to CMS. Our audit work was performed at Mutual of Omaha in Omaha, Nebraska during February 2002 through September 2002.

RESULTS OF AUDIT

Medical reviewers determined that 25 claims out of 151 tested did not comply with Medicare laws and regulations. As a result, providers received $12,070 in improper payments and one underpayment of $7,016 out of a total of $530,367 reviewed. These improper payments resulted from medical reviewers' determinations that services were unnecessary, coded incorrectly, not sufficiently documented or not rendered. A detailed description of each medical service denial is reported in Appendix A. When these claims were originally submitted to Mutual, they contained no visible errors.

For the three-month audit period, we verified the reconciliation of monthly CMS 1521 and 1522 Forms to Mutual's paid claims tapes, bank statements, journals, and system reports. From this review of Mutual's records, we found that Mutual's controls over the reconciliation process were adequate and that the reconciliations were accurate, supported, complete and properly classified.

CONCLUSION AND RECOMMENDATION

Medicare payments totaling $12,070 should be denied and recovery actions should be taken.

AUDITEE COMMENTS

Mutual of Omaha concurred with our recommendation. At the exit conference, Mutual agreed to recover the $12,070 in overpayments listed in Appendix A.

Sincerely,

Jack Norman

for James P. Aasmundstad
Regional Inspector General
for Audit Services

CFO AUDIT
MUTUAL OF OMAHA
OMAHA, NE
2nd QUARTER FEDERAL FISCAL YEAR 2002
SCHEDULE OF ERROR CLAIMS DURING MEDICAL REVIEW

ICN	Denied Services	Error Code	Reason for Denial		Denied Amount
1135180636	2	25	Medically Unnecessary Service or Treatment	$	3.50
1135180636	1	25	Medically Unnecessary Service or Treatment		1.75
1135180636	1	25	Medically Unnecessary Service or Treatment		1.75
1135180636	1	16	No Documentation		1.75
1136552221	1	31	Services Incorrectly Coded		0.00
1200222624	1	31	Services Incorrectly Coded		804.82
1200885650	1	31	Services Incorrectly Coded		0.00
1200967850	-4	31	Services Incorrectly Coded	(1)	(841.32)
1200967850	4	25	Medically Unnecessary Service or Treatment	(1)	1446.32
1201440577	1	41	Services Billed Were Not Rendered		11.16
1201440577	1	41	Services Billed Were Not Rendered		11.94
1203786280	1	31	Services Incorrectly Coded		0.00
1203926247	1	25	Medically Unnecessary Service or Treatment		5.64
1203926247	1	25	Medically Unnecessary Service or Treatment		2.52
1203926247	1	25	Medically Unnecessary Service or Treatment		2.68
1205280596	5	25	Medically Unnecessary Service or Treatment	(2)	1734.60
1205280596	-1	31	Services Incorrectly Coded	(2)	(327.44)
1205912891	1	41	Services Billed Were Not Rendered		420.84
1206673932	1	31	Services Incorrectly Coded		469.76
1206686593	1	31	Services Incorrectly Coded		0.00
1206715673	1	66	Invalid Patient Admission		3350.34
1207124075	1	66	Invalid Patient Admission		4128.29
1207126636	1	25	Medically Unnecessary Service or Treatment		7.56
1207126636	1	25	Medically Unnecessary Service or Treatment		3.25
1207126637	1	25	Medically Unnecessary Service or Treatment		13.42
1252961603	1	31	Services Incorrectly Coded		0.00
1253525303	1	21	Insufficient Documentation		14.61
1253525303	1	21	Insufficient Documentation		6.50
1253525303	1	21	Insufficient Documentation		25.42
1253525303	1	21	Insufficient Documentation		10.74
1253525303	1	21	Insufficient Documentation		11.16
1253525303	1	21	Insufficient Documentation		5.93
1253525303	1	21	Insufficient Documentation		11.94
1253525303	1	21	Insufficient Documentation		4.37
1253616359	6	41	Services Billed Were Not Rendered		33.45
1253616359	2	35	Not Covered or Unallowable Service		2.59
1257422112	2	41	Services Billed Were Not Rendered		86.58
2021718580	1	25	Medically Unnecessary Service or Treatment		3.85
2021718580	1	25	Medically Unnecessary Service or Treatment		3.85
2021718580	1	25	Medically Unnecessary Service or Treatment		3.85
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2021718580	1	25	Medically Unnecessary Service or Treatment	3.85
2021718580	1	25	Medically Unnecessary Service or Treatment	3.85
2025017952	1	25	Medically Unnecessary Service or Treatment	3.37
2025017952	1	25	Medically Unnecessary Service or Treatment	3.37
2025017952	1	25	Medically Unnecessary Service or Treatment	3.37
2025017952	1	25	Medically Unnecessary Service or Treatment	3.37
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2025017952	1	25	Medically Unnecessary Service or Treatment	3.37
2025017952	1	25	Medically Unnecessary Service or Treatment	3.35
2025017952	1	25	Medically Unnecessary Service or Treatment	28.85
2025017952	1	25	Medically Unnecessary Service or Treatment	28.85
2025017952	1	25	Medically Unnecessary Service or Treatment	28.85
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2025017952	1	25	Medically Unnecessary Service or Treatment	28.85
2025017952	1	25	Medically Unnecessary Service or Treatment	28.85
2027916698	1	25	Medically Unnecessary Service or Treatment	3.67
2027916698	1	25	Medically Unnecessary Service or Treatment	3.67
2027916698	1	25	Medically Unnecessary Service or Treatment	3.67
2027916698	1	25	Medically Unnecessary Service or Treatment	3.67
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2027916698	1	25	Medically Unnecessary Service or Treatment	3.67
2027916698	1	25	Medically Unnecessary Service or Treatment	3.67
2126316494	1	41	Services Billed Were Not Rendered	36.38
			Total	$ 12,070.06
1204417332	1	31	Services Incorrectly Coded	(3) (7,015.65)
	141			

(1) Same claim with an underpayment and overpayment to the provider.
(2) Same claim with an underpayment and overpayment to the provider.
(3) Underpayment to the provider.