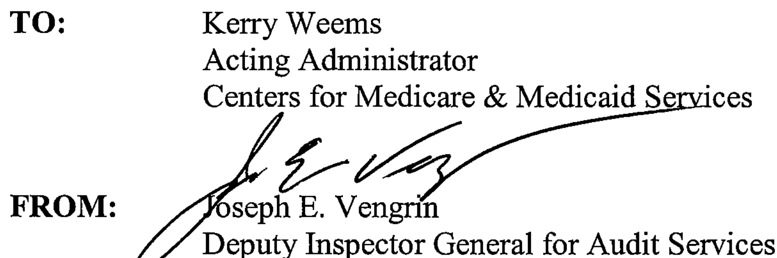
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 15 2008

TO: Kerry Weems
Acting Administrator
Centers for Medicare & Medicaid Services



FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Excessive Payments for Inpatient Services Processed by National Government Services in Michigan and Wisconsin for Calendar Years 2004 and 2005 (A-05-07-00069)

Attached is an advance copy of our final report on excessive payments for inpatient services processed by National Government Services in Michigan and Wisconsin for calendar years (CY) 2004 and 2005. We will issue this report to National Government Services 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 National Government Services made to hospitals for inpatient services were appropriate.

Of the 172 high-dollar payments that National Government Services made to hospitals for inpatient services for CYs 2004 and 2005, 65 were appropriate. The remaining 107 payments included net overpayments totaling $1,574,089, of which $1,328,739 for 105 payments had not been repaid at the start of our audit.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units for blood clotting factor, reported incorrect diagnosis-related group codes on their claims, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to data entry errors, insufficient documentation to support charges, and a misunderstanding of how to report charges. National Government Services 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 National Government Services:

- recover the $1,328,739 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.

In written comments on our draft report, National Government Services agreed with the recommendations and stated that the 105 claims representing overpayments of $1,328,739 were adjusted and monies were recovered by April 30, 2008.

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 Marc Gustafson, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through e-mail at Marc.Gustafson@oig.hhs.gov. Please refer to report number A-05-07-00069.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES — OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region V
233 North Michigan Ave. Suite 1360
Chicago, IL 60601-5519
(312) 353-2618

SEP 18 2008

Report Number: A-05-07-00069

Ms. Sandy 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 Excessive Payments for Inpatient Services Processed by National Government Services in Michigan and Wisconsin for Calendar Years 2004 and 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 Jaime Saucedo, Audit Manager, at (312) 353-8693 or through e-mail at Jaime.Saucedo@oig.hhs.gov. Please refer to report number A-05-07-00069 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

cc:
Ms. Sarah Litteral
Director, Part A/RHHI Claims
National Government Services
9001 Linn Station Road
Louisville, Kentucky 40223

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management and 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 EXCESSIVE PAYMENTS FOR INPATIENT SERVICES PROCESSED BY NATIONAL GOVERNMENT SERVICES IN MICHIGAN AND WISCONSIN FOR CALENDAR YEARS 2004 AND 2005

Daniel R. Levinson
Inspector General

September 2008
A-05-07-00069

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.

Notices

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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 to process claims. The Common Working File can detect certain improper payments during prepayment validation.

Section 1886(d) of the Act established the prospective payment system (PPS) for inpatient hospital services. Under the PPS, 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. Section 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides that PPS hospitals receive payment, in addition to the basic DRG payment, for blood clotting factor administered to hemophilia inpatients. 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 (CY) 2004 and 2005, United Government Services was the fiscal intermediary in Wisconsin and Michigan. United Government Services processed approximately 1.7 million inpatient claims during this period, 172 of which resulted in payments of $200,000 or more (high-dollar payments). In January 2007, National Government Services assumed the business operations of United Government Services.

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 172 high-dollar payments that National Government Services made to hospitals for inpatient services for CYs 2004 and 2005, 65 were appropriate. The remaining 107 payments included net overpayments totaling $1,574,089, of which $1,328,739 for 105 payments had not been repaid at the start of our audit.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units for blood clotting factor, reported incorrect DRG codes on their claims, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to data entry errors, insufficient documentation to support charges, and a misunderstanding of how to report charges. National Government Services 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.

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $1,328,739 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.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, National Government Services agreed with our recommendations and stated that the 105 claims representing overpayments of $1,328,739 were adjusted and monies were recovered by April 30, 2008. National Government Services' comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

Page

INTRODUCTION 1

BACKGROUND 1
Medicare Fiscal Intermediaries 1
Claims for Inpatient Services 1
National Government Services 2

OBJECTIVE, SCOPE, AND METHODOLOGY 2
Objective 2
Scope 2
Methodology 2

FINDINGS AND RECOMMENDATIONS 3

FEDERAL REQUIREMENTS 3

INAPPROPRIATE HIGH-DOLLAR PAYMENTS 4

CAUSES OF OVERPAYMENTS 4

RECOMMENDATIONS 5

NATIONAL GOVERNMENT SERVICES COMMENTS 5

APPENDIX

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

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 to process hospitals' inpatient claims. The Common Working File 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 (PPS) for inpatient hospital services. Under the PPS, 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 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides that PPS hospitals receive payment, in addition to the basic DRG payment, for blood clotting factor administered to hemophilia inpatients. Also, 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

[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.

reports on its claim and the hospital-specific cost-to-charge ratio. Inaccurately reporting charges could lead to excessive outlier payments.

National Government Services

During our audit period (CYs 2004 and 2005), United Government Services was the fiscal intermediary in Wisconsin and Michigan. United Government Services processed approximately 1.7 million inpatient claims during this period, 172 of which resulted in high-dollar payments. In January 2007, National Government Services assumed the business operations of United Government Services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 172 high-dollar payments, which totaled $48,555,636, for inpatient claims that National Government Services processed during CYs 2004 and 2005. We limited our review of National Government Services' internal controls to those applicable to the 172 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 June 2007 through February 2008. Our fieldwork included contacting National Government Services, located in Milwaukee, Wisconsin, and the hospitals 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 Common Working File 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 National Government Services 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 findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 172 high-dollar payments that National Government Services made to hospitals for inpatient services for CYs 2004 and 2005, 65 were appropriate. The remaining 107 payments included net overpayments totaling $1,574,089, of which $1,328,739 for 105 payments had not been repaid at the start of our audit.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units for blood clotting factor, reported incorrect DRG codes on their claims, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to data entry errors, insufficient documentation to support charges, and a misunderstanding of how to report charges. National Government Services 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.

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 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides that PPS hospitals receive an additional payment for the cost of administering a blood clotting factor to Medicare beneficiaries with hemophilia during an inpatient stay.[3] The payment is based on a predetermined price per unit of clotting factor multiplied by the number of units provided. During our audit period, the "Medicare Claims Processing Manual," Pub. No. 100-04, Chapter 3, section 20.7.3, required 100 international units (IU) of the clotting factor to be reported as

[3]Section 6011(d) was amended by section 13505 of the Omnibus Budget Reconciliation Act of 1993 (P.L. No. 103-66) and section 4452 of the Balanced Budget Act of 1997 (P.L. No. 105-33) so that it is effective for discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997.

1 billing unit. In reporting the number of billing units, hospitals divide the number of IUs administered by 100.[4]

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

National Government Services made net overpayments totaling $1,328,739 for 105 payments that hospitals had not refunded prior to the start of our audit. Hospitals received these overpayments by inaccurately reporting the number of billing units for blood clotting factor, reporting incorrect DRG codes on their claims, and reporting excessive charges that resulted in inappropriate outlier payments. The following examples illustrate the high-dollar overpayments:

- A hospital reported inaccurate blood factor units because it did not divide the IUs by 100 as required. As a result, National Government Services paid the hospital $449,511 when it should have paid $37,156, a $412,355 overpayment.

- A hospital submitted a claim with a principal diagnosis code of pneumonia, DRG code 89, for which the reimbursement amount was $307,790. As a result of our inquiry, the hospital reviewed its medical records and determined that the proper diagnosis code was chronic respiratory failure, DRG code 87, for which the reimbursement amount was $247,420. As a result, National Government Services overpaid the hospital $60,370.

- A hospital was reimbursed $216,427 for a claim that included $85,039 in excessive pharmacy charges because of data entry errors. As a result, National Government Services overpaid the hospital $28,827 in outlier payments.

CAUSES OF OVERPAYMENTS

Providers attributed most of the incorrect claims to data entry errors, insufficient documentation to support charges, and a misunderstanding of how to report charges. National Government Services made the 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. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive

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[4]Effective July 14, 2006, CMS Transmittal 903, Change Request 4229, instructed fiscal intermediaries to (1) no longer multiply the payment amount by 100 when loading the fee amounts to the Healthcare Common Procedure Coding System file for inpatient hemophilia clotting factor and (2) instruct their providers to no longer divide the number of units by 100 when billing for clotting factor.

payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[5]

RECOMMENDATIONS

We recommend that National Government Services:

- recover the $1,328,739 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.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, National Government Services agreed with our recommendations and stated that the 105 claims representing overpayments of $1,328,739 were adjusted and monies were recovered by April 30, 2008. National Government Services' comments are included in their entirety as the Appendix.

[5]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

Medicare

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

A CMS Contracted Agent

August 15, 2008

Mr. Marc Gustafson
Regional Inspector General for Audit Services
Office of Inspector General, Region V
233 North Michigan Avenue
Chicago, IL 60601

Re: Response to Draft Report Number A-05-07-00069

Dear Mr. Gustafson:

This letter is in response to the above referenced draft report entitled "Review of Excessive Payments for Inpatient Services Processed by National Government Services in Michigan and Wisconsin for Calendar Years 2004 and 2005."

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

1. The 105 claims representing overpayments of $1,328,739 were adjusted and monies were recovered by April 30, 2008.
2. NGS will 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.
3. 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 Sarah Litteral, Claims Director, at 502-329-8584.

Sincerely,

David Crowley
Staff Vice President
Claims Management

cc: Sarah Litteral, Part A/RHHI Claims Director