DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

JUN 17 2009

TO: Charlene Frizzera
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 Wisconsin Physicians Service for Calendar Years 2004 Through 2006—Hospitals With Fewer Than Five High-Dollar Payments (A-05-08-00061)

Attached is an advance copy of our final report on high-dollar payments for inpatient services processed by Wisconsin Physicians Service for calendar years 2004 through 2006 for hospitals with fewer than five high-dollar payments. We will issue this report to Wisconsin Physicians Service within 5 business days. This audit was part of a nationwide review of payments for inpatient services of $200,000 or more (high-dollar payments).

Our objective was to determine whether selected high-dollar Medicare payments that Wisconsin Physicians Service made to hospitals for inpatient services were appropriate.

Of the 249 high-dollar payments that Wisconsin Physicians Service made to hospitals for inpatient services for calendar years 2004 through 2006, 28 were appropriate. The 221 remaining payments included net overpayments totaling $3,851,272, which the hospitals had not refunded prior to the start of our audit.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units for blood clotting factor, reported incorrect diagnosis and procedure codes, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. Wisconsin Physicians Service 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 Wisconsin Physicians Service:

- recover the $3,851,272 in identified net overpayments,

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

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

In written comments on our draft report, Wisconsin Physicians Service described corrective actions that it had taken or planned to take to implement our recommendations.

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) 353-2618 or through e-mail at Marc.Gustafson@oig.hhs.gov. Please refer to report number A-05-08-00061.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

JUN 22 2009

Report Number: A-05-08-00061

Mr. Guy Ringle
Senior Vice President, Medicare
Wisconsin Physicians Service
P.O. Box 1787
Madison, Wisconsin 53708-1787

Dear Mr. Ringle:

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 Wisconsin Physicians Service for Calendar Years 2004 Through 2006—Hospitals With Fewer Than Five High-Dollar Payments." 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 Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. 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 Stephen Slamar, Audit Manager, at (312) 353-7905 or through e-mail at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-08-00061 in all correspondence.

Sincerely,

Marc Gustafson
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 WISCONSIN PHYSICIANS SERVICE FOR CALENDAR YEARS 2004 THROUGH 2006—HOSPITALS WITH FEWER THAN FIVE HIGH-DOLLAR PAYMENTS

Daniel R. Levinson
Inspector General

June 2009
A-05-08-00061

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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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

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 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 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides that prospective payment system hospitals receive payment, in addition to the basic diagnosis-related group 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 2004 through 2006, Mutual of Omaha Insurance Company was a fiscal intermediary for providers in all States except New York. Mutual of Omaha Insurance Company processed approximately 6.9 million inpatient claims during this period, 249 of which resulted in payments of $200,000 or more (high-dollar payments) to hospitals that each received fewer than 5 such payments. In November 2007, Wisconsin Physicians Service assumed the fiscal intermediary operations of Mutual of Omaha Insurance Company.

OBJECTIVE

Our objective was to determine whether selected high-dollar Medicare payments that Wisconsin Physicians Service made to hospitals for inpatient services were appropriate.

SUMMARY OF FINDING

Of the 249 high-dollar payments that Wisconsin Physicians Service made to hospitals for inpatient services for calendar years 2004 through 2006, 28 were appropriate. The 221 remaining payments included net overpayments totaling $3,851,272, which the hospitals had not refunded prior to the start of our audit.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units for blood clotting factor, reported incorrect diagnosis and procedure codes, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. Wisconsin Physicians Service 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 Wisconsin Physicians Service:

- recover the $3,851,272 in identified net overpayments,
- use the results of this audit in its provider education activities related to data entry procedures and proper documentation, and
- consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.

WISCONSIN PHYSICIANS SERVICE COMMENTS

In written comments on our draft report, Wisconsin Physicians Service described corrective actions that it had taken or planned to take to implement our recommendations. Wisconsin Physicians Service's comments are included in their entirety 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 to process hospitals' inpatient claims. The Common Working File can detect certain improper payments during prepayment validation.

In calendar years (CY) 2004 through 2006, fiscal intermediaries processed and paid approximately 40.6 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 (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 costs 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.

Wisconsin Physicians Service

During CYs 2004 through 2006, Mutual of Omaha Insurance Company was a fiscal intermediary for providers in all States except New York. Mutual of Omaha Insurance Company processed approximately 6.9 million inpatient claims during this period, 769 of which resulted in high-dollar payments. In November 2007, Wisconsin Physicians Service assumed the fiscal intermediary operations of Mutual of Omaha Insurance Company.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether selected high-dollar Medicare payments that Wisconsin Physicians Service made to hospitals for inpatient services were appropriate.

Scope

We reviewed 249 of the 769 high-dollar payments for inpatient claims that Wisconsin Physicians Service processed during CYs 2004 through 2006. The 249 high-dollar payments, which totaled $65,511,072, were made to hospitals that each received fewer than 5 such payments during our audit period. We are separately reviewing the 520 remaining high-dollar payments totaling $145,930,365 that were made to hospitals that each received 5 or more such payments (report number A-05-08-00051).

We limited our review of Wisconsin Physicians Service's internal controls to those applicable to the 249 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 CMS's National Claims History file, but we did not assess the completeness of the file.

We conducted our fieldwork from March 2008 through February 2009. Our fieldwork included contacting Wisconsin Physicians Service, located in Madison, 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 the 249 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 Wisconsin Physicians Service that partial inappropriate payments 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 249 high-dollar payments that Wisconsin Physicians Service made to hospitals for inpatient services for CYs 2004 through 2006, 28 were appropriate. The 221 remaining payments included net overpayments totaling $3,851,272, which the hospitals had not refunded prior to the start of our audit.

Contrary to Federal guidance, hospitals inaccurately reported the number of billing units for blood clotting factor, reported incorrect diagnosis and procedure codes, and reported excessive charges that resulted in inappropriate outlier payments. Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. Wisconsin Physicians Service 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

Section 1815(a) of the Act prohibits Medicare payment for claims not supported by sufficient documentation. 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 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.

[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) 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, respectively.

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

Wisconsin Physicians Service made 221 net overpayments totaling $3,851,272, which hospitals had not refunded prior to the start of our audit. The overpayments involved hospital claims submitted with inaccurate data, including the incorrect number of billing units for blood clotting factor, incorrect diagnosis and procedure codes, and excessive charges that resulted in inappropriate outlier payments.

Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. Wisconsin Physicians Service made these inappropriate payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place to detect and prevent these types of inappropriate payments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of inappropriate payments and on beneficiaries to review their "Medicare Summary Notice" and disclose any inappropriate payments.[4]

RECOMMENDATIONS

We recommend that Wisconsin Physicians Service:

- recover the $3,851,272 in identified net overpayments,
- use the results of this audit in its provider education activities related to data entry procedures and proper documentation, and
- consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.

WISCONSIN PHYSICIANS SERVICE COMMENTS

In written comments on our draft report, Wisconsin Physicians Service described corrective actions that it had taken or planned to take to implement our recommendations. Wisconsin Physicians Service's comments are included in their entirety as the Appendix.

[4]The fiscal intermediary sends a "Medicare Summary 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

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

May 15, 2009

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

Re: OIG Blue Book Audit A-05-08-00061 – April 2009

Dear Mr. Gustafson:

This letter is in response to the Draft OIG Blue Book titled "Review of High-Dollar Payments for Inpatient Services Processed by Wisconsin Physicians Service for Calendar Years 2004 Through 2006-Hospitals With Fewer Than Five High-Dollar Payments."

The OIG reviewed 249 high-dollar payments that Wisconsin Physicians Service made to hospitals for inpatient services for CYs 2004 through 2006, 28 were appropriate. The 221 remaining payments included net overpayments totaling $3,851,272, which the hospitals had not refunded prior to the start of their audit.

OIG Recommendations:

- *recover the $3,851,272 in identified net overpayments,*
- *use the results of this audit in its provider education activities related to data entry procedures and proper documentation, and*
- *consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.*

At this point WPS has recovered nearly all of the 221 overpayments identified and intends to recoup the remaining ones as soon as feasible, within the limitations of the four year reopening period.

The results of this audit will be utilized, where applicable, in future educational activities. Subject to the current limitations within FISS, controls will be enhanced, as needed, to reduce the likelihood of high dollar claim overpayments.

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

Sincerely,

Mark DeFoil
Director, Contract Coordination

cc: John Phelps, CMS
Lisa Goschen, CMS
Stephen Slamar, OIG