



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

OCT 1 2008

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-07-06022

Mr. Bruce W. Hughes
President and Chief Operating Officer
Palmetto GBA
2300 Springdale Drive, Building 1
Camden, South Carolina 29020

Dear Mr. Hughes:

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 Palmetto GBA, Intermediary #380, 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 P.L. No. 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 pt. 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 (904) 232-2687 or through e-mail at Mary.Moreno@oig.hhs.gov. Please refer to report number A-04-07-06022 in all correspondence.

Sincerely,

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

Page 2 – Mr. Bruce W. Hughes

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
PALMETTO GBA, INTERMEDIARY
#380, FOR THE PERIOD
JANUARY 1, 2004, THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

October 2008
A-04-07-06022

Office of Inspector General

<http://oig.hhs.gov>

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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. 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, Palmetto GBA (Palmetto) was the fiscal intermediary in South Carolina. During this period, Palmetto processed 39 inpatient claims totaling \$10.1 million that had payments of \$200,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 39 high-dollar payments that Palmetto made to hospitals for inpatient services for CYs 2004 and 2005, 23 were appropriate. The remaining 16 payments included 9 overpayments totaling \$110,930 that had not been repaid at the start of our audit and 7 payments for which we were unable to determine the overpayment amount.

Contrary to Federal guidance, hospitals reported units of service inaccurately. Hospitals attributed most of the incorrect claims to clerical errors. Palmetto made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place in CYs 2004 and 2005 to detect the errors.

RECOMMENDATIONS

We recommend that Palmetto:

- refund the \$110,930 in identified overpayments related to nine payments;
- take appropriate action on the remaining seven payments with excessive units for which we were unable to determine the overpayment amount;
- use the results of this audit in its provider education activities related to proper documentation and data entry procedures; and
- consider implementing controls to identify and review all payments greater than \$200,000 for inpatient services.

PALMETTO GBA COMMENTS

In its August 27, 2008, written comments on our draft report, Palmetto agreed to recover the \$110,930 in overpayments and adjust the 16 claims (9 related to the identified overpayments and 7 for which overpayment amounts were not determined). Palmetto stated that it would use the results of this audit to enhance its existing provider education activities. Additionally, Palmetto stated that it would implement controls to identify and review all payments greater than \$200,000 for inpatient services. The complete text of Palmetto'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.

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 Medicare 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.

¹Outlier payments occur when a hospital's charges for a particular Medicare beneficiary's inpatient stay substantially exceed the DRG payment.

²A 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.

Palmetto GBA

During our audit period (CYs 2004 and 2005), Palmetto GBA (Palmetto) was the fiscal intermediary in South Carolina. Palmetto processed 39 high-dollar inpatient claims during the period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 39 high-dollar inpatient claims totaling \$10,116,834 processed during CYs 2004 and 2005. We limited our review of Palmetto's internal control structure to those controls applicable to the 39 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 a reasonable assurance regarding 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 July 2007 through May 2008. Our fieldwork included contacting Palmetto, located in Columbia, South Carolina, 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 Medicare Part A inpatient claims with high-dollar payments;
- reviewed available CWF claims histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by a revised claim or whether the 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
- validated with Palmetto that 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 39 high-dollar payments that Palmetto made to hospitals for inpatient services for CYs 2004 and 2005, 23 were appropriate. The remaining 16 payments included 9 overpayments totaling \$110,930 that had not been repaid at the start of our audit and 7 payments for which we were unable to determine the overpayment amount.

Contrary to Federal guidance, hospitals reported units of service inaccurately. Hospitals attributed most of the incorrect claims to clerical errors. Palmetto made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place in CYs 2004 and 2005 to detect the errors.

FEDERAL REQUIREMENTS

CMS's "Medicare Claims Processing Manual," Publication No. 100-04, Chapter 1, section 80.3.2.2, requires hospitals to submit accurate claims to fiscal intermediaries to receive reimbursement for inpatient services. Chapter 4, section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed."

Section 3700 of CMS's "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

Section 1886(d)(5)(A) of the Act provides for Medicare outlier payments to hospitals, in addition to prospective payments, for cases incurring extraordinarily high costs. CMS provides for 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 exceed the DRG payment for the case.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Palmetto made overpayments totaling \$110,930 for nine payments that hospitals had not refunded prior to the start of our audit. For the remaining seven payments, hospitals also reported excessive billing units; however, we were unable to determine the overpayment amount because of other factors affecting the re-pricing of the claims.³

³When the claims were originally paid, the cost to charge ratios, disproportionate share hospital ratios, and Indirect Medical Education ratios used were outdated. Repricing the claims using updated information for the dates of service of the claims resulted in the cost to charge ratio increasing.

CAUSES OF OVERPAYMENTS

Hospitals attributed most of the incorrect claims to clerical errors and to the reporting of excessive charges that resulted in inappropriate outlier payments. In addition, Palmetto made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place in CYs 2004 and 2005 to detect the errors. 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 errors.⁴

RECOMMENDATIONS

We recommend that Palmetto:

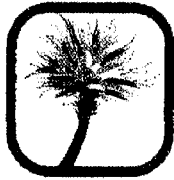
- refund the \$110,930 in identified overpayments related to nine payments;
- take appropriate action on the remaining seven payments with excessive units for which we were unable to determine the overpayment amount;
- use the results of this audit in its provider education activities related to proper documentation and data entry procedures; and
- consider implementing controls to identify and review all payments greater than \$200,000 for inpatient services.

PALMETTO GBA COMMENTS

In its August 27, 2008, written comments on our draft report, Palmetto agreed to recover the \$110,930 in overpayments and adjust the 16 claims (9 related to the identified overpayments and 7 for which overpayment amounts were not determined). Palmetto stated that it would use the results of this audit to enhance its existing provider education activities. Additionally, Palmetto stated that it would implement controls to identify and review all payments greater than \$200,000 for inpatient services. The complete text of Palmetto’s comments is included as the Appendix.

⁴The 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



Palmetto GBA
PARTNERS IN EXCELLENCE™

Bruce W. Hughes
President and Chief Operating Officer

August 27, 2008

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

Reference: Draft Report No. A-04-07-06022

Dear Mr. Barbera:

This letter is in response to the recent Office of Inspector General (OIG) draft report entitled "Review of High-Dollar Payments for Inpatient Services Processed by Palmetto GBA, Intermediary #380, for the Period January 1, 2004, Through December 31, 2005." We appreciate the feedback that your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

As stated in the draft report, overall it was found that 16 of the 39 inpatient claims reviewed resulted in overpayments totaling \$110,930. It was determined that the hospitals inaccurately reported units of service. The hospitals attributed the incorrect claims to clerical errors. At the time, Palmetto GBA made the overpayments because it did not have prepayment or postpayment controls to identify aberrant payments at the claim level. In addition, neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during calendar years 2004 and 2005 to detect and prevent excessive payments.

Palmetto GBA will adhere to the recommendation of implementing controls to identify and review all payments greater than \$200,000. Typically the review of records to substantiate level of service, (i.e. medical necessity of an inpatient admission, length of stay, and certain procedures) is the responsibility of the QIO. However, we continue to explore opportunities to expand and implement additional prepayment edits to mitigate excessive payments.

Palmetto GBA will also adhere to the recommendations set forth by the OIG review to recover the \$110,930 in identified overpayments. Palmetto GBA will adjust the 16 claims and all providers will be notified of the anticipated adjustment. We anticipate timely completion of all adjustments upon receipt of claims listing.

In addition, Palmetto GBA maintains a consistent approach in our provider education strategy focusing on accurate billing, documentation of claims data with emphasis on claims data reflecting the services provided are medically reasonable and necessary. In 2007, we proactively implemented a reason code to perform an assessment of high dollar claims, 70045 - *Review for Possible Overpayment*. Provider outreach and education was completed relevant to billing and the implementation of reason code 70045.

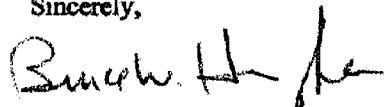
Peter J. Barbera
August 27, 2008
Page 2

Articles were published that addressed the high dollar edit and the application to all bill types. In addition, we presented practical information for use when filing high dollar claims in our 2007 Summer Hospital Workshop and South Carolina hospital state association meeting. Palmetto GBA continues to take a very tangible approach to provider education delivering clear, concise, and timely instruction in all possible educational venues.

Future educational efforts will be further enhanced to leverage data from this review in order to perform targeted areas of billing relevant to high-dollar payments for inpatient services. We intend to cover this topic in our ACT call on September, 11, 2008; develop an enhanced provider education article for the Palmetto GBA website as well as, include an article in the next monthly Medicare Advisory.

Thank you for providing Palmetto GBA with the opportunity to provide feedback regarding your review. If you have any questions, please do not hesitate to contact me.

Sincerely,



cc: Sandra Y. Brown, Atlanta Regional Office, CMS
John Delaney, Dallas Regional Office, CMS