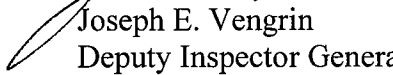




MAR 25 2009

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 National Government Services in Illinois, Indiana, Kentucky, and Ohio for Calendar Years 2004 Through 2006 (A-05-08-00028)

Attached is an advance copy of our final report on high-dollar payments for inpatient services processed by National Government Services in Illinois, Indiana, Kentucky, and Ohio for calendar years 2004 through 2006. We will issue this report to National Government Services 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 National Government Services made to hospitals for inpatient services were appropriate.

Of the 303 high-dollar payments that National Government Services made to hospitals for inpatient services for calendar years 2004 through 2006, 39 were appropriate. The remaining 264 payments included net overpayments totaling \$7,444,904. At the start of our audit, hospitals had refunded overpayments totaling \$2,752,167 for 4 claims but had not refunded net overpayments totaling \$4,692,737 for 260 claims.

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 payments. Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. 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 \$4,692,737 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, National Government Services agreed with our recommendations and described corrective actions that it had taken or planned to take.

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-05-08-00028.

Attachment



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

REGION V
OFFICE OF
INSPECTOR GENERAL

MAR 30 2009

Report Number: A-05-08-00028

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 High-Dollar Payments for Inpatient Services Processed by National Government Services in Illinois, Indiana, Kentucky, and Ohio for Calendar Years 2004 Through 2006." 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 Steve Slamar, Audit Manager, at (312) 353-7905 or through e-mail at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-08-00028 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "Marc Gustafson".

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
NATIONAL GOVERNMENT
SERVICES IN ILLINOIS, INDIANA,
KENTUCKY, AND OHIO FOR
CALENDAR YEARS
2004 THROUGH 2006**



Daniel R. Levinson
Inspector General

March 2009
A-05-08-00028

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.

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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.

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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.

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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

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

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, AdminaStar Federal was the fiscal intermediary for Illinois, Indiana, Kentucky, and Ohio. AdminaStar Federal processed approximately 5.2 million inpatient claims during this period, 303 of which resulted in payments of \$200,000 or more (high-dollar payments) to hospitals that each received 10 or more such payments. In January 2007, National Government Services assumed the business operations of AdminaStar Federal.

OBJECTIVE

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

SUMMARY OF FINDING

Of the 303 high-dollar payments that National Government Services made to hospitals for inpatient services for calendar years 2004 through 2006, 39 were appropriate. The remaining 264 payments included net overpayments totaling \$7,444,904. At the start of our audit, hospitals had refunded overpayments totaling \$2,752,167 for 4 claims but had not refunded net overpayments totaling \$4,692,737 for 260 claims.

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. 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 \$4,692,737 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.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, National Government Services agreed with our recommendations and described corrective actions that it had taken or planned to take. National Government Services' 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.

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.

National Government Services

During CYs 2004 through 2006, AdminaStar Federal was the fiscal intermediary for Illinois, Indiana, Kentucky, and Ohio. AdminaStar Federal processed approximately 5.2 million inpatient claims during this period, 472 of which resulted in high-dollar payments. In January 2007, National Government Services assumed the business operations of AdminaStar Federal.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed 303 of the 472 high-dollar payments for inpatient claims that National Government Services processed during CYs 2004 through 2006. The 303 high-dollar payments, which totaled \$96,092,571, were made to hospitals that each received 10 or more such payments during our audit period. We separately reviewed the remaining 169 high-dollar payments totaling \$63,502,261 that were made to hospitals that each received fewer than 10 such payments (report number A-05-08-00027).

We limited our review of National Government Services' internal controls to those applicable to the 303 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 December 2007 through September 2008. Our fieldwork included contacting National Government Services, located in Chicago, Illinois, 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 303 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 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 findings and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the 303 high-dollar payments that National Government Services made to hospitals for inpatient services for CYs 2004 through 2006, 39 were appropriate. The remaining 264 payments included net overpayments totaling \$7,444,904. At the start of our audit, hospitals had refunded overpayments totaling \$2,752,167 for 4 claims but had not refunded net overpayments totaling \$4,692,737 for 260 claims.

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. 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

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.

³Section 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

National Government Services made 260 net overpayments totaling \$4,692,737, 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. National Government Services 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 National Government Services:

- recover the \$4,692,737 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.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, National Government Services agreed with our recommendations and described corrective actions that it had taken or planned to take. National Government Services' comments are included in their entirety as the Appendix.

⁴The 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



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

A CMS Contracted Agent

Medicare

February 17, 2009

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-05-08-00028

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 Illinois, Indiana, Kentucky, and Ohio for Calendar Years 2004 through 2006."

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

1. The 260 claims representing overpayments of \$4,692,737 were adjusted and monies were recovered by September 30, 2008, with the exception of three providers who did not submit adjustments for a total of 55 claims and one provider where two claims were not adjusted due to the DRG. NGS will make one final contact with the providers to get the claims corrected. If the adjustments are not initiated within 15 days of notification, the claims will be cancelled.
2. The information identified in this review will be shared with our Provider Outreach and Education Department to ensure providers are aware of correct billing procedures.
3. The information will also be shared with our Medical Review (MR) Department so that they may determine if this review should be part of their MR Strategy.

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,

A handwritten signature in cursive script that reads "David Crowley".

David Crowley
Staff Vice President
Claims Management

cc: Sarah Litteral, Part A/RHHI Claims Director

