DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

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

NOV 17 2008

Report Number: A-04-08-00051

Ms. Lynda Northcutt, President
Cahaba Government Benefit Administrators, LLC
300 Corporate Parkway
Birmingham, Alabama 35242

Dear Ms. Northcutt:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Outpatient Claims Processed by Cahaba Government Benefit Administrators Fiscal Intermediary No. 00010 for the Period January 1, 2004, Through December 31, 2006." We will forward a copy of this report to the HHS action official 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, the final 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 Eric Bowen, Audit Manager, at (404) 562-7789 or through e-mail at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-08-00051 in all correspondence.

Sincerely,

Peter J Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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 OUTPATIENT CLAIMS PROCESSED BY CAHABA GOVERNMENT BENEFIT ADMINISTRATORS FISCAL INTERMEDIARY NO. 00010 FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2006

Daniel R. Levinson
Inspector General

November 2008
A-04-08-00051

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.

Office of Evaluation and Inspections

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.

Office of Investigations

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.

Office of Counsel to the Inspector General

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 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 claims submitted by hospital outpatient departments. 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.

Medicare guidance requires hospitals to claim outpatient services using the appropriate Healthcare Common Procedure Coding System codes and to report units of services as the number of times that a service or procedure was performed.

During calendar years (CY) 2004 – 2006, Cahaba Government Benefit Administrators contractor No. 00010 (Cahaba GBA) was the fiscal intermediary in Alabama and processed six outpatient claims with payments of $50,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Cahaba GBA's high-dollar outpatient payments to Alabama providers were appropriate.

SUMMARY OF FINDINGS

Of the six high-dollar payments that Cahaba GBA made for outpatient services for CYs 2004 – 2006, one was appropriate. The remaining five payments included overpayments totaling $355,356.

Contrary to Federal guidance, hospitals reported excessive units of service and charges that resulted in inappropriate payments. Generally, hospitals attributed the overpayments to incorrect claims data. Cahaba GBA made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments.

RECOMMENDATION

We recommend that Cahaba GBA recover the $355,356 in identified overpayments.

AUDITEE COMMENTS

In written comments to our draft report, Cahaba GBA agreed with the report. Cahaba GBA stated that the recommendation was reasonable and that it would await direction from CMS before acting on the recommendation and making adjustments. Cahaba GBA's comments are included as the Appendix.

TABLE OF CONTENTS

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 claims submitted by hospital outpatient departments. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

To process hospitals' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System (FISS) and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validations.

In calendar years (CY) 2004 – 2006 fiscal intermediaries processed and paid approximately 418.4 million outpatient claims, 1,317 of which resulted in payments of $50,000 or more (high-dollar payments).

Claims for Outpatient Services

Medicare guidance requires hospitals to submit accurate claims for outpatient services. Hospitals should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed.

Cahaba Government Benefit Administrators

During our audit period (CYs 2004 – 2006), Cahaba Government Benefit Administrators contractor No. 00010 (Cahaba GBA) was the fiscal intermediary in Alabama. Cahaba GBA processed six outpatient claims during this period that resulted in high-dollar payments totaling $444,931.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Government Benefit Administrators high-dollar outpatient payments to Alabama providers were appropriate.

Scope

We reviewed the six high-dollar payments for outpatient claims that Cahaba GBA processed during CYs 2004 – 2006. We limited our review of Cahaba GBA's internal controls to those applicable to the six high-dollar payments 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 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 performed fieldwork from November 2007 through April 2008. Our fieldwork included contacting Cahaba GBA, located in Birmingham, Alabama, and the hospitals, located in Alabama, 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 outpatient claims with high-dollar Medicare payments;
- reviewed available CWF claims histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork; and
- 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.

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.

FINDINGS AND RECOMMENDATION

Of the six high-dollar payments that Cahaba GBA made to Alabama hospitals for outpatient services for CYs 2004 – 2006, one was appropriate. The remaining five payments included overpayments totaling $355,356.

Contrary to Federal guidance, hospitals reported excessive units of service and charges that resulted in inappropriate payments. Generally, hospitals attributed the overpayments to incorrect claims data. Cahaba GBA made these incorrect payments because neither the FISS nor the CWF had sufficient edits in place to detect and prevent the overpayments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of this manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

Section 3700 of the "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."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Hospitals reported excessive units of service and charges on five claims, resulting in overpayments totaling $355,356. The following example illustrates the overpayments:

- A hospital reported 3,600 units of service among four claims for the drug Oxaliplatin instead of 360 units of service. As a result of the 3,240 excess units of service claimed, Cahaba GBA overpaid the hospital approximately $273,812.

CAUSES OF OVERPAYMENTS

Generally, hospitals attributed the overpayments to incorrect claims data. In addition, Cahaba GBA made the incorrect payments because neither the FISS nor the CWF had sufficient edits in place to detect and prevent the overpayments. In effect, CMS relied on providers to notify intermediaries of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[1]

[1]The intermediary sends a "Medicare Summary Notice" to the beneficiary after the provider files a claim for Medicare service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

FISCAL INTERMEDIARY PREPAYMENT EDIT

On January 3, 2006, during our audit period, CMS required intermediaries to implement a FISS edit to suspend potentially excessive Medicare payments for prepayment review. The edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

We did not find any errors occurring after the implementation of the prepayment edit.

RECOMMENDATION

We recommend that Cahaba GBA recover the $355,356 in identified overpayments.

AUDITEE COMMENTS

In written comments to our draft report, Cahaba GBA agreed with the report. Cahaba GBA stated that the recommendation was reasonable and that it would await direction from CMS before acting on the recommendation and making adjustments. Cahaba GBA's comments are included as the Appendix.

APPENDIX

APPENDIX

Lynda Northcutt
President
Cahaba Government Benefit Administrators,® LLC

October 6, 2008

Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Attention: Eric Bowen, Audit Manager
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

RE: Report Number: A-04-08-00051 Review of High-Dollar Outpatient Claims Processed by Cahaba Government Benefits Administrator Fiscal Intermediary No. 00010 for the Period January 1, 2004, Through December 31, 2006.

Dear Mr. Bowen:

We agree with captioned report; its recommendations were reasonable. We await direction from the Centers for Medicare and Medicaid Services before we act on the recommendations and make adjustments.

If you should have any questions regarding this report, please contact Molly Echols, Manager Risk and Compliance at (205) 220-1587 or via email at Mechols@cahabagba.com.

Sincerely,

Lynda Northcutt
President
Cahaba Government Benefit Administrators®, LLC

LN/jm

cc: Brandon Ward, Vice President of Operations, Cahaba GBA
Jim Hill, Divisional Manager, Cahaba GBA
David Brown, Director, Cahaba GBA Administration