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

OCT 8 2008

Report Number: A-04-07-07020

Rodney Woods, President & CEO
Blue Cross and Blue Shield of Tennessee
dba Riverbend GBA
730 Chestnut Street
Chattanooga, Tennessee 37402

Dear Mr. Woods:

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 and Outpatient Claims Processed by Riverbend Government Benefits Administrator 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 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 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 Andrew Funtal, Audit Manager, at (404) 562-7762 or through e-mail at Andrew.Funtal@oig.hhs.gov. Please refer to report number A-04-07-07020 in all correspondence.

Sincerely,

Peter J. Barbera

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR INPATIENT AND OUTPATIENT CLAIMS PROCESSED BY RIVERBEND GOVERNMENT BENEFITS ADMINISTRATOR FOR CALENDAR YEARS 2004 AND 2005

Daniel R. Levinson
Inspector General

October 2008
A-04-07-07020

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 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, which administers the program, contracts with fiscal intermediaries to administer Medicare Part A and some Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying hospitals for services provided. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

To process hospitals' inpatient and outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as the Centers for Medicare & Medicaid Services' Common Working File (CWF). The CWF can detect certain improper payments when processing claims for prepayment validation.

Medicare guidance requires hospitals to bill services accurately, using proper Health Care Common Procedure Coding System codes, and reporting units of service specifying the number of times the service or procedure was performed.

In calendar years (CY) 2004 and 2005, fiscal intermediaries processed and paid 5,125 inpatient claims of $200,000 or more and 989 outpatient claims of $50,000 or more. We considered such payments to be high-dollar payments. BlueCross BlueShield of Tennessee Inc. doing business as Riverbend Government Benefits Administrator (Riverbend) was a Medicare Part A intermediary primarily serving Medicare hospitals in Tennessee and New Jersey and processed approximately 21 million claims during CYs 2004 and 2005. Of these 21 million claims, only 223 inpatient and 83 outpatient claims resulted in high-dollar payments.

OBJECTIVE

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

SUMMARY OF FINDINGS

Most of the high-dollar Medicare payments were appropriate. During CYs 2004 and 2005, Riverbend made 306 high-dollar payments for inpatient and outpatient services. Our analysis indicated that, at the start of our fieldwork in June of 2007:

- One-hundred-sixty of the payments were correct, as initially paid.

- Forty-six of the payments were incorrect as initially paid; however, Riverbend identified the overpayments and the hospitals had refunded the $5,524,122 in overpayments.

- One hundred of the payments were incorrect, and the hospitals had not refunded the $4,910,063 in overpayments.

Riverbend had controls in place for high-dollar charges during our audit period, which contributed to the number of correct payments it processed. However, Riverbend made some inappropriate payments because neither its system nor the CWF had sufficient edits in place during CYs 2004 or 2005 to detect billing errors related to Health Care Common Procedure Coding System codes and units of service.

RECOMMENDATION

We recommend that Riverbend recover the $4,910,063 in identified overpayments.

RIVERBEND COMMENTS

In written comments, Riverbend agreed with the findings and recommendation in our draft report. Riverbend stated that it had updated its internal procedures to base high-dollar claims review on claims reimbursements rather than on claims charges of $1 million or more. Riverbend also stated that of the 100 identified overpayments, providers corrected 89 claims and Riverbend cancelled the remaining 11 claims to recoup the overpayments. In addition, Riverbend would review claims paid after the time period covered by the audit. Riverbend'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 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.

Fiscal Intermediary Responsibilities

CMS contracts with fiscal intermediaries to administer Medicare Part A and some Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to hospitals for services provided. Federal guidance provides that intermediaries maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

Claims for Inpatient and Outpatient Services

To process hospitals' inpatient and outpatient claims, the intermediaries use the Fiscal Intermediary Standard System, as well as CMS's Common Working File (CWF). The CWF can detect certain improper payments when processing claims for prepayment validation.

Medicare guidance requires hospitals to bill services accurately, using proper Healthcare Common Procedure Coding System (HCPCS) codes, and to report units of service specifying the number of times the service or procedure was performed.

In calendar years (CY) 2004 and 2005, fiscal intermediaries processed and paid 5,125 inpatient claims of $200,000 or more and 989 outpatient claims of $50,000 or more. We considered such payments to be high-dollar payments.

Riverbend

During our audit period (CYs 2004 and 2005), BlueCross BlueShield of Tennessee Inc. doing business as Riverbend Government Benefits Administrator (Riverbend) was a Medicare Part A intermediary primarily serving Medicare hospitals in Tennessee and New Jersey. Riverbend processed approximately 21 million claims during CYs 2004 and 2005. Of these 21 million claims, only 223 inpatient and 83 outpatient claims resulted in high-dollar payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed the 223 inpatient claims and the 83 outpatient claims Riverbend paid during CYs 2004 and 2005. We limited our review of Riverbend's internal control structure to those controls applicable to the 306 (223 inpatient and 83 outpatient) claims because our objective did not require an understanding of all internal controls over claims submission or claims processing. 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 did not perform or request medical review on any of the 306 claims.

We conducted our fieldwork from June through December 2007 by working with Riverbend, located in Chattanooga, Tennessee and hospitals in Tennessee, New Jersey, and Mississippi that received high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify inpatient claims and outpatient claims with high-dollar Medicare payments;
- reviewed available CWF claims histories for high-dollar inpatient and outpatient claims to determine whether those claims had been canceled and superseded by a revised claim or whether the payments remained outstanding at the time of our fieldwork;
- analyzed claims that were reviewed by Riverbend to determine whether more information was needed from the hospitals;
- contacted the hospitals associated with the high-dollar payments to determine whether (1) the units of service shown on the claims were correct and, if not, why the claims were billed in error and (2) the hospitals agreed that a refund was appropriate; and
- validated with Riverbend that the claims were billed in error, 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.ur audit objectives.

FINDINGS AND RECOMMENDATION

Most of the high-dollar Medicare payments were appropriate. During CYs 2004 and 2005, Riverbend made 306 high-dollar payments for inpatient and outpatient services. Our analysis indicated that, at the start of our fieldwork in June of 2007:

- One-hundred-sixty of the payments were correct as initially paid.

- Forty-six of the payments were incorrect as initially paid; however, Riverbend identified the overpayments and the hospitals had refunded the $5,524,122 in overpayments.

- One hundred of the payments were incorrect, and the hospitals had not refunded the $4,910,063 in overpayments.

Riverbend had controls in place for high-dollar charges during our audit period, which contributed to the number of correct payments it processed. However, Riverbend made some inappropriate payments because neither its system nor the CWF had sufficient edits in place during CYs 2004 or 2005 to detect billing errors related to HCPCS codes and units of service.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the HCPCS. The Medicare "Hospital Manual," section 400 states: "Bill only for services provided. If your system initiates billing based on services ordered, you must confirm that the service has been provided before billing either the carrier or intermediary. Furthermore, section 462 states: "In order to be paid correctly and promptly, a bill must be completed accurately."

Also, 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

Of the 306 high-dollar payments that Riverbend made to hospitals during CYs 2004 and 2005, 160 were appropriate. The remaining 146 payments (71 inpatient and 75 outpatient) totaling $10,434,185 were inappropriate. At the start of our fieldwork in June 2007, Riverbend had identified and refunded 46 overpayments (22 inpatient and 24 outpatient) totaling $5,524,122. One hundred overpayments (49 inpatient and 51 outpatient) totaling $4,910,063 remained outstanding.

Claim Type	Correct claim payments	Number of Improper Payments	Number of Improper Payments Refunded	Refund Amount	Improper Payments Not Refunded	Overpayment Amount Outstanding
Inpatient	152	71	22	$4,084,639	49	$1,600,613
Outpatient	8	75	24	$1,439,483	51	$3,309,450
Total	**160**	**146**	**46**	**$5,524,122**	**100**	**$4,910,063**

The following examples illustrate billing errors that hospitals made.

- Twelve hospitals overstated/understated the units of service billed due to inadequate controls and edits or employee errors, including lack of documentation. Riverbend overpaid a net of $1,584,386 to the 12 hospitals for 28 claims.

- Three hospitals overstated the units of service billed for the drug Oxaliplatin by 10 times more than the number of units actually delivered due to an error with the unit rate. As a result, Riverbend overpaid $1,423,921 to the three hospitals for 25 claims.

- Five hospitals overstated the units of services billed due to computer interface billing system issues or employee errors. Riverbend overpaid $769,018 to the five hospitals for nine claims.

- Three hospitals overstated the units of service billed due to measuring the units of service in minutes or components rather than as one unit. As a result, Riverbend overpaid $587,426 to the three hospitals for nine claims.

- Three hospitals erroneously billed the wrong HCPCS. Riverbend overpaid $151,469 to the three hospitals for three claims.

CAUSES OF OVERPAYMENTS

Although Riverbend had both prepayment and postpayment controls in place, neither its system nor the CWF had sufficient edits in place in CYs 2004 or 2005 to detect billing errors related to HCPCS codes and units of services. Instead, CMS relied on providers to

notify intermediaries of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[1]

On January 3, 2006, subsequent to our audit period but prior to our fieldwork, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends outpatient claims of $50,000 or more and requires intermediaries to contact hospitals to determine the legitimacy of the claims.

RECOMMENDATION

We recommend that Riverbend recover the $4,910,063 in identified overpayments.

RIVERBEND COMMENTS

In written comments, Riverbend agreed with the findings and recommendation in our draft report. Riverbend stated that it had updated its internal procedures to base high-dollar claims review on claims reimbursements rather than on claims charges of $1 million or more. Riverbend also stated that of the 100 identified overpayments, providers corrected 89 claims and Riverbend cancelled the remaining 11 claims to recoup the overpayments. In addition, Riverbend would review claims paid after the time period covered by the audit. Riverbend's comments are included in their entirety as the Appendix.

[1]The fiscal intermediary sends a "Medicare Summary Notice" to the beneficiary after the provider 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

www.cms.gov

Medicare
Part A Intermediary

July 22, 2008

Mr. Peter J. Barbera
Office of Inspector General
Office of Audit Services
Region IV
61 Forsyth Street, S.W. Suite 3T41
Atlanta, GA 30303

RE: Report Number A-04-07-07020
Review of High-Dollar Payments for Inpatient and Outpatient Claims Processed by Riverbend Government Benefits Administrator for Calendar Years 2004 and 2005

Dear Mr. Barbera:

On behalf of Riverbend Government Benefits Administrator (Riverbend), I would like to thank the Office of Inspector General for the opportunity to comment on your findings. Within the context of the authority and funding made available to us as a contractor, Riverbend is committed to assisting the Centers for Medicare and Medicaid Services (CMS) in identifying and reducing the Medicare Program's vulnerability to reimbursements of inappropriate claims for payments to providers. We consider the information contained in this review as important feedback that we will use in assessing our processes as part of our continuous improvement commitment. Our more specific comments to your findings are reflected below.

The overall issue identified during our review is that our internal review is based on billed charges of one million dollars or greater. To improve our internal process and protect the Medicare Trust Fund, Riverbend has determined it will be most effective to base high-dollar claims review on claims reimbursement. Our internal procedures have been updated to reflect this change.

As stated in the report, 306 claims with high dollar payments were initially reviewed. The majority of these claims were paid appropriately. One hundred claims were identified as potential overpayments; 86 have been corrected by the provider. There were 14 claims outstanding when the draft report was issued; three have been corrected by the provider. Riverbend has cancelled the remaining 11 claims to recoup the overpayments.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare
Part A Intermediary

www.cms.gov

Riverbend will review claims paid after the time period covered by the audit. We will work with providers to determine if claims were billed appropriately and take necessary actions to recoup any overpayments.

If you have any questions or need additional information, you may contact me at (423) 535-4243 or via e-mail at john.hayes@rgbagov.com.

Best Regards,

J. Hayes

John R. Hayes
Chief Operating Officer
Riverbend Government Benefits Administrator