



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

April 27, 2011

Report Number: A-05-09-00100

Ms. Sandra Miller
President
National Government Services, Inc.
8115 Knue Road
Indianapolis, IN 46250

Dear Ms. Miller:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of High-Dollar Payments Processed by National Government Services for Long-Term Care Inpatient Services Provided Between October 1, 2006, and December 31, 2007*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted 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 email at Stephen.Slamar@oig.hhs.gov. Please refer to report number A-05-09-00100 in all correspondence.

Sincerely,

/James C. Cox/
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 (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR
PAYMENTS PROCESSED BY
NATIONAL GOVERNMENT SERVICES
FOR LONG-TERM CARE INPATIENT
SERVICES PROVIDED BETWEEN
OCTOBER 1, 2006, AND
DECEMBER 31, 2007**



Daniel R. Levinson
Inspector General

April 2011
A-05-09-00100

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 Medicare contractors to process and pay Medicare Part A claims submitted by hospitals. The Medicare contractors use the Fiscal Intermediary Shared System and CMS's Common Working File to process claims. The Common Working File can detect certain improper payments during prepayment validation.

Section 123 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113, established the long-term care hospital prospective payment system. Under the long-term care hospital prospective payment system, CMS pays long-term care hospital costs at predetermined rates for patient discharges. The rates vary according to the long-term care hospital diagnosis-related group to which a beneficiary's stay is assigned. CMS's *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 long-term care hospital diagnosis-related group payment is, with certain exceptions, payment in full to the long-term care hospital for all inpatient services. Federal regulations at 42 CFR § 412.521(b) provides that the long-term care hospital receive payment, in addition to the basic long-term care diagnosis related group payment, for blood clotting factor administered to hemophilia inpatients. Also, section 307(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. No.106-554, provides for an additional Medicare payment, known as an outlier payment, to long-term care hospitals for cases incurring extraordinarily high costs.

Until December 2006, AdminaStar Federal was a Medicare contractor in Illinois, Indiana, Kentucky and Ohio. In January 2007, National Government Services, a subsidiary of WellPoint, assumed the Medicare contractor operations of the AdminaStar Federal. During October 2006 through December 2007, National Government Services and its predecessor AdminaStar Federal processed approximately 7,600 long-term care hospital inpatient claims, 126 of which resulted in high-dollar payments.

OBJECTIVE

Our objective was to determine whether the 126 high-dollar Medicare payments that National Government Services made to long-term care hospitals for inpatient services were appropriate.

SUMMARY OF FINDING

Fifty-eight, or 46 percent, of the 126 high-dollar payments that National Government Services made to long-term care hospitals for inpatient services during the period October 2006 through December 2007 were inappropriate. The inappropriate payments included net overpayments totaling \$326,618, which the hospitals had not refunded before the start of our audit. The remaining 68 payments were appropriate.

Contrary to Federal guidance, hospitals inaccurately reported the number of blood clotting factor units, diagnosis and procedure codes, and charges that resulted in inappropriate payments for claims. Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. Neither the Fiscal Intermediary Shared System nor the Common Working File had sufficient edits in place so National Government Services could detect and prevent these types of inappropriate payments.

RECOMMENDATIONS

We recommend that National Government Services:

- recover the \$326,618 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 \$125,000 for inpatient services.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, National Government Services stated that the overpayments were recovered as of April 7, 2011. Regarding our second and third recommendations, the National Government Services has referred them to the appropriate parties within the organization for further consideration and action.

National Government Services' comments are 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 Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted by hospitals.¹ The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process hospitals' inpatient claims, the Medicare contractors use the Fiscal Intermediary Shared System and CMS's Common Working File. The Common Working File can detect certain improper payments during prepayment validation.

During October 2006 through December 2007, Medicare contractors processed and paid approximately 175,000 long-term care hospital inpatient claims, 2,078 of which resulted in payments of \$125,000 or more (high-dollar payments).²

Claims for Long-Term Care Hospital Services

Section 123 of the Medicare, Medicaid, and SCHIP [State Children's Health Insurance Program] Balanced Budget Refinement Act of 1999, P.L. No. 106-113, established the long-term care hospital prospective payment system for inpatient hospital services.³ Under the long-term care hospital prospective payment system, CMS pays long-term care hospital costs at predetermined rates for patient discharges. The rates vary according to the long-term care hospital diagnosis-related group (LTC-DRG) to which a beneficiary's stay is assigned. The LTC-DRG payment is, with certain exceptions, payment in full to the long-term care hospital for all inpatient costs associated with the beneficiary's stay. CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, section 10.1, requires that hospitals submit claims on the appropriate forms for

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, or MAC, whichever is applicable.

² Section 1886(d)(1)(B)(iv)(I) of the Act defines a long-term care hospital as "a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days."

³ Section 114(e) of the Medicare, Medicaid and SCHIP Extension Act of 2007, Pub. L. 110-173, incorporated section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 into section 1886 (m) of the Act.

all provider billings, and chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

Federal regulations at 42 CFR § 412.521(b) provides that the long-term care hospital receive payment, in addition to the basic LTC-DRG payment, for blood clotting factor administered to hemophilia inpatients. Also, section 307(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. No.106-554, provides for an additional Medicare payment, known as an outlier payment, to long-term care hospitals for cases incurring extraordinarily high costs.^{4,5} The Medicare contractor identifies outlier cases by comparing the estimated costs of a case with a LTC- DRG specific fixed-loss threshold.⁶ To estimate the costs of a case, the Medicare contractor uses the Medicare charges that the hospital reports on its claim and the hospital-specific cost-to-charge ratio based on its most recent settled cost report. Inaccurately reporting charges could lead to excessive outlier payments.

National Government Services

Until December 2006, AdminaStar Federal was a Medicare contractor in Illinois, Indiana, Kentucky and Ohio. In January 2007, National Government Services, a subsidiary of WellPoint, assumed the Medicare contractor operations of the AdminaStar Federal. During October 2006 through December 2007, National Government Services and its predecessor AdminaStar Federal processed approximately 7,600 long-term care hospital claims, 126 of which resulted in high-dollar payments.

The name "National Government Services" used in this report refers to the current Medicare contractor National Government Services and its predecessor AdminaStar Federal.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the 126 high-dollar Medicare payments that National Government Services made to long-term care hospitals for inpatient services were appropriate.

⁴ Section 114(e) of the Medicare, Medicaid and SCHIP Extension Act of 2007, P.L. 110-173, incorporated section 307(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 into section 1886 (m) of the Act.

⁵ Outlier payments occur when a hospital's charges for a particular Medicare beneficiary's long-term care hospital inpatient stay substantially exceed the LTC-DRG payment.

⁶ A LTC-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.

Scope

We reviewed 126 high-dollar payments for inpatient claims that National Government Services processed during October 2006 through December 2007.

We limited our review of National Government Services' internal controls to those applicable to the 126 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.

Our fieldwork included contacting National Government Services, located in Indianapolis, Indiana 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 long-term care inpatient claims with high-dollar Medicare payments;
- reviewed available Common Working File claim histories for the 126 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 long-term care 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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Fifty-eight, or 46 percent, of the 126 high-dollar payments that National Government Services made to long-term care hospitals for inpatient services during the period October 2006 through December 2007 were inappropriate. The inappropriate payments included net overpayments

totaling \$326,618, which the hospitals had not refunded before the start of our audit. The remaining 68 payments were appropriate.

Contrary to Federal guidance, hospitals inaccurately reported the number of blood clotting factor units, diagnosis and procedure codes, and charges that resulted in inappropriate payments for claims. Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. Neither the Fiscal Intermediary Shared System nor the Common Working File had sufficient edits in place so National Government Services could detect and prevent these types of inappropriate payments.

FEDERAL REQUIREMENTS

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

Federal regulations at 42 CFR § 412.521(b) provides that the long-term care hospitals, in addition to LTC-DRG payments, receive additional payments for the cost of administering blood clotting factors to Medicare beneficiaries with hemophilia during an inpatient stay. The payment is based on a predetermined price per unit of clotting factor multiplied by the number of units provided.

Section 307(b)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, P.L. No.106-554, provides for Medicare outlier payments to long-term care hospitals, in addition to LTC-DRG payments, for cases incurring extraordinarily high costs. CMS provides for these additional payments, as specified in 42 CFR § 412.525(a), 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 LTC-DRG payment for the case.

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

National Government Services made 58 net overpayments totaling \$326,618, which hospitals had not refunded before the start of our audit. The overpayments involved hospital claims submitted with inaccurate numbers of blood clotting factor units, diagnosis and procedure codes, and charges that resulted in inappropriate claim payments.

Hospitals attributed most of the incorrect claims to data entry errors and insufficient documentation. Neither the Fiscal Intermediary Shared System nor the Common Working File had sufficient edits in place so National Government Services could detect and prevent these types of inappropriate payments.

RECOMMENDATIONS

We recommend that National Government Services:

- recover the \$326,618 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 \$125,000 for inpatient services.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, National Government Services stated that the overpayments were recovered as of April 7, 2011. Regarding our second and third recommendations, the National Government Services has referred them to the appropriate parties within the organization for further consideration and action.

National Government Services' comments are included as the Appendix.

APPENDIX



National Government Services, Inc.
8115 Kinn Road
Indianapolis, Indiana 46250-1936
A CMS Contracted Agent

APPENDIX: AUDITEE COMMENTS

Medicare

April 18, 2011

Mr. James C. Cox
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

RE: Report Number: A-05-09-00100

Dear Mr. Cox:

The following is the National Government Service's (NGS) response to the Regional Inspector General Office draft report entitled *Review of High-Dollar Payments Processed by National Government Services for Long-Term Care(LTCH) Inpatient Services Provided Between October 1, 2006 and December 31, 2007*.

After review of your recommendations, we have the following responses:

- recover the \$326,618.00 in identified net overpayments

This recovery was verified as complete on April 7, 2011.

NOTE:

A member of our Claims Processing staff was in contact with Mr. Ampalathumkal, before validating this audit of the #'s. Our findings are that all of the net overpayments have been processed and the dollar amounts agree with 1 exception – which was \$.01 discrepancy: *On Line 77 of the enclosed report.* ❖

- ❖ We have omitted the enclosure referenced in the National Government Services' comments because it contains personally identifiable information.



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

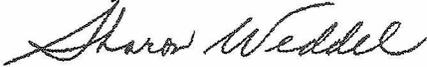
This information has been forwarded to our Provider Education department, under Mr. Michael Davis, for their further consideration and action.

- Consider implementing controls to identify and review all payments greater than \$125,000 for Inpatient Services

This recommendation will be referred to our NGS Data Analysis Team for further consideration and action. This team reviews / recommends various identification editing for all claims, including LTCH services.

As we await your final report, we will be working on your final two recommendations and will provide updates as they are received.

Sincerely,



Sharon Weddel, Director, NGS Operations
National Government Services, Inc.

Cc:

David A. Marshall, Vice President,
Government Administration Segment

Michael Davis, Manager, Medicare POE
NGS-Medicare