Memorandum

Date MAY 15 1992

From Richard P. Kusserow
Inspector General

Subject Review of Processing of Medicare Credit Balances at Blue Cross/Blue Shield of Connecticut (A-01-91-00515)

To William Toby
Acting Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on May 18, 1992, of our final report. A copy is attached.

Our audit of procedures used for processing outstanding Medicare credit balances at Blue Cross/Blue Shield of Connecticut (hereafter referred to as the Intermediary) and eight randomly selected Connecticut hospitals showed that improvements are needed to ensure that identified Medicare overpayments are promptly refunded to the Medicare program. Our review at 8 sampled hospitals from a population of 15 showed that, as a whole, the hospitals did not always follow established procedures for refunding Medicare overpayments within a reasonable time frame (60 days). In addition, we also noted that hospitals had attempted to return overpayments to the Intermediary, but the Intermediary did not always take action to process the adjustments. In this regard, we noted a lack of coordination among the Intermediary's various claims processing units which precluded a timely resolution of the credit balance adjustments. Moreover, credit balance reviews were not always performed by the Intermediary's provider audit unit during its field audits of hospitals' Medicare cost reports because of other priorities. We believe that these factors contributed to the untimely recoupment of Medicare overpayments, which we have projected to be about $1.3 million for the eight sampled hospitals. For the remaining seven Connecticut hospitals in our population, our analysis at the Intermediary disclosed an additional $1.6 million in Medicare overpayments not refunded to the Medicare program within the required time frame.

We recommend that the Intermediary: (1) reemphasize to all hospitals to report and refund all credit balances within a reasonable time frame, (2) establish internal control procedures, including a focal point within the Intermediary, for reprocessing credit balance adjustments

within required time frames, (3) require provider auditors to review hospitals' compliance with credit balance requirements during their field audits, (4) process adjustments for all outstanding credit balances identified in our detailed review of the eight sampled hospitals (projected to be about $1.3 million), and (5) review and process the $1.6 million in outstanding credit balances for the seven hospitals not included in our sample.

In separate audit reports addressed to the eight hospitals, we recommended that the hospitals establish or implement procedures for refunding Medicare credit balances and to reimburse the Medicare program for the credit balances identified in our audit, which we projected to be about $1.3 million.

In response to our draft report, Intermediary officials indicated that they have reemphasized credit balance instructions to providers and tightened control procedures to monitor and process credit balance adjustments within proper time frames. The Intermediary also reported that it has processed credit balance adjustments of $6,931,479 since January 1991. These adjustments represent recoveries from the 15 hospitals noted in our report. The amounts are greater than those included in our recommendation because the Intermediary's adjustments are for a time frame that extends beyond our audit period.

For further information, contact:
Richard J. Ogden
Regional Inspector General
for Audit Services, Region I
FTS: 835-2687

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PROCESSING OF MEDICARE CREDIT BALANCES AT BLUE CROSS/BLUE SHIELD OF CONNECTICUT

Richard P. Kusserow
INSPECTOR GENERAL

A-01-91-00515

OFFICE OF INSPECTOR GENERAL

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
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CIN: A-01-91-00515

Mr. James Buccheri
Vice President of Government Operations
Blue Cross/Blue Shield of Connecticut
370 Bassett Road
North Haven, Connecticut 06473

Dear Mr. Buccheri:

This audit report provides you with the results of our audit of the processing of outstanding Medicare credit balances by Blue Cross/Blue Shield of Connecticut (hereafter referred to as the Intermediary). The objectives of our review were (1) to determine if outstanding credit balances recorded on the accounting records of eight randomly selected hospitals represented unrecovered Medicare overpayments and (2) to assess the Intermediary's controls for identifying and processing hospital credit balances.

Our audit showed that both the hospitals and the Intermediary need to improve their procedures and controls to ensure that all Medicare credit balances are reviewed timely and that identified Medicare overpayments are refunded to the Medicare program or otherwise resolved. We found that the eight sampled hospitals, as a whole, did not always follow established procedures for refunding Medicare overpayments within a reasonable time frame (60 days). At the Intermediary, we noted a lack of coordination among its various claims processing units which precluded a timely resolution of the credit balance adjustments. Moreover, credit balance reviews were not always performed by the Intermediary's provider audit group during its field audit because of other priorities. We believe that these factors contributed to the untimely recoupment of the Medicare overpayments, which we have projected to be about $1.3 million for the eight sampled hospitals. For the remaining seven Connecticut hospitals not included in the sample our analysis at the Intermediary disclosed an additional $1.6 million in Medicare overpayments which had not been refunded to the Medicare program within the required time frame.

We recommend that the Intermediary (1) reemphasize to all hospitals to report and refund all credit balances within a reasonable time frame, (2) establish internal control procedures, including a focal point within the Intermediary, for processing credit balance adjustments within required time frames, (3) require provider auditors to review hospitals' compliance with credit balance requirements during their field audits, (4) process adjustments for all outstanding credit

balances identified in our detailed review of the eight sampled hospitals (projected to be about $1.3 million), and (5) review and process the $1.6 million in adjustments for the seven hospitals not included in our sample.

In separate audit reports addressed to the eight hospitals, we recommended that the hospitals establish or revise procedures for refunding Medicare credit balances and to reimburse the Medicare program for the credit balances identified in our audit, which we projected to be about $1.3 million.

In response to our draft report Intermediary officials generally agreed with our recommendations and indicated that it has reemphasized credit balance instructions to providers and implemented internal control procedures to monitor and process credit balance adjustments within proper time frames. The Intermediary reported that adjustments of $6,931,479, recovered since January 1991, have been credited to the Medicare program.

BACKGROUND

The Social Security Act (the Act) Amendments of 1983 (Public Law 98-21) established the prospective payment system (PPS) of reimbursement to hospitals participating in the Medicare program. Under PPS, hospitals are reimbursed prospectively on a per discharge basis. However, certain types of costs, including outpatient services, are excluded from the hospitals' PPS reimbursements and are reimbursed on a reasonable cost basis. Medicare reimbursement for both inpatient and outpatient services are made by Fiscal Intermediaries (FIs) contracted by the Health Care Financing Administration (HCFA). Intermediaries are required to audit hospital cost reports to ensure that the costs adhere to Federal regulations and HCFA guidelines. The Intermediary for the hospitals in our review is Blue Cross/Blue Shield of Connecticut.

In processing Medicare claims for payment, a Medicare credit balance occurs when reimbursement for services provided to a Medicare beneficiary exceed the charges billed according to the provider's accounting records. A credit balance does not necessarily mean an overpayment has occurred. Some Medicare credit balances result from accounting errors and errors in calculating coinsurance amounts. These types of errors generally do not result in overpayments. Other Medicare credit balances result from duplicate payments made by an intermediary, payments made for an anticipated service that was not actually provided or from payments made by an intermediary and other insurers for the same service provided to the same patient. In these cases, a Medicare overpayment exists and should be refunded to the intermediary.

SCOPE

Our audit was made in accordance with generally accepted Government auditing standards. The objectives of our audit were (1) to determine if outstanding credit balances recorded on the hospitals accounting records represented unrecovered Medicare overpayments and (2) to assess the Intermediary's controls for identifying and processing hospital credit balances.

Our audit is part of a nationwide review of hospital Medicare credit balances being conducted by the Office of Inspector General (OIG). In this regard, the Intermediary and eight hospitals served by it were randomly selected for this audit.

To accomplish our first audit objective, we selected a random sample of those credit balances on hospital records at the time of our review. The primary sampling unit was a hospital with a bed capacity of 200 or more and the secondary sampling unit was Medicare credit balances valued at $100 or more. There are fifteen 200-bed hospitals that are serviced by the Intermediary of which 8 were randomly selected. At each of the 8 sampled hospitals, we randomly selected 100 credit balances for review. If a hospital had less than 100 credit balances in the universe, we reviewed all credit balances. In addition, we examined all credit balances valued over $10,000. We utilized a variable appraisal program to estimate the total amount of inpatient and outpatient credit balances representing overpayments due the Medicare program for each of the sampled eight hospitals.

We determined the extent of overpayments due the Medicare program by analyzing Medicare credit balances at the eight hospitals. We reviewed such records as credit balance accounts, patient files, remittance advices and Medicare payment histories. We limited our evaluation of each hospitals' internal control structure because we concluded that the audits could be conducted more efficiently by expanding substantive testing, thus, placing very little reliance on the internal control structure at each hospital.

For the eight hospitals reviewed, inpatient and outpatient Medicare outstanding credit balances amounted to $2,944,294 and $1,584,674, respectively. The total number of outstanding inpatient and outpatient Medicare credit balances totaled 1,514 and 3,289, respectively. These included credit balances on the hospital listings as of March 26, 1991 through April 25, 1991.

To accomplish our second objective, we performed an evaluation of the Intermediary's internal control structure for processing hospital credit balance adjustments. Specifically, we reviewed the Intermediary's claims processing and provider audit

functions. We traced the credit balances identified at the hospitals reviewed to the Intermediary's records to determine whether an adjustment was made. In addition, we analyzed the amount of credit balances reported by the seven hospitals not included in our sample to determine what action was taken by the Intermediary.

For those items tested, we found no instances of noncompliance except for those matters discussed in the Results of Audit section of this report. With respect to the items not tested, nothing came to our attention to cause us to believe that the untested items would have shown results which varied from the results of the tested items.

Our field work was performed at the eight Connecticut hospitals (see Appendix I) and at the Intermediary's offices in Meriden, Connecticut during the period April through October 1991. On January 17, 1992, we provided the Intermediary with a draft report for comment. Its comments are appended to this report (see Appendix II) and summarized on page 8.

RESULTS OF AUDIT

Credit Balance Reviews at Selected Hospitals

Our audit of eight Medicare participating hospitals serviced by the Intermediary showed that at the time of our review all of the hospitals had Medicare credit balances recorded on their accounting records that exceeded a reasonable time limit (60 days).

We reviewed 1,370 Medicare inpatient and outpatient credit balances at the hospitals and found that 457 (33 percent) represented Medicare overpayments totaling $963,004 ($782,802 for inpatient services and $180,202 for outpatient services). Based on a standard scientific estimation process at each of the eight sampled hospitals, we concluded Medicare overpayments due the Medicare program totaling $820,394 for inpatient and $495,518 for outpatient services were on the hospitals' accounting records at the time of our review. Results of our review at each hospital were reported under separate common identification numbers. The amount of overpayments identified at each hospital are summarized in Appendix I to this report. The amounts listed for the separate hospitals are lower bounds and there is a 95 percent probability that the overpayment is at least the amount stated for each hospital.

We identified three primary causes for the Medicare overpayments, as follows:

- Medicare secondary payer (MSP) situations - Both Medicare and another insurer mistakenly paid primary for the same service when Medicare should have paid secondary.

- Duplicate billings - Hospitals billed for services in total and by component, for different service dates or procedure codes.

- Services not performed - Hospital billed in anticipation of a service being rendered. The service was later cancelled.

Our review disclosed that although each hospital had procedures in place to review and process Medicare credit balances, in many instances the procedures were not being followed. As a result, overpayments caused by the above noted situations were not resolved within a reasonable time frame (60 days).

Hospital officials indicated that they have attempted, in some cases, to return overpayments to the Intermediary, but the adjustments were never processed by the Intermediary. In this regard, some of the hospitals responding to our audit reports provided the following comments relative to their difficulties in attempting to get the Intermediary to process the necessary adjustments.

- "...the Intermediary did not act on our numerous requests to resolve these accounts...." (St. Vincent's Hospital)

- "...the Intermediary is unable to process credit balances on a timely basis...." (Yale-New Haven Hospital)

- "...The hospital has in the past tried to return Medicare credit balances to our Fiscal Intermediary, Connecticut Blue Cross with limited response...." (Stamford Hospital)

Intermediary Processing of Credit Balance Recoveries

In order to analyze all aspects of the credit balance situation, we conducted the second phase of our review at the Intermediary. As noted above, some hospitals expressed concern that the Intermediary was a contributing factor to the problem of unresolved credit balances. Our review at the Intermediary, disclosed that the Intermediary's procedures for identifying

and processing adjustment claims were not adequate and had, in fact, contributed to the untimely processing of Medicare overpayments.

For each outstanding credit balance we identified at the eight hospitals, we examined the Intermediary's computerized claims files and hospital remittance advises and found no evidence of adjustments. We reviewed the Intermediary's procedures for adjusting overpayments and found little being done to identify credit balances and ensure prompt recovery. We found that the Intermediary did not have any specific unit established to handle notification of overpayments received from the hospitals. In this regard, responsibility for processing adjustments was scattered among the inpatient, outpatient and MSP units of the Intermediary with little or no coordination among these units. As a result, even those claims identified by the hospitals as overpayments were not being adjusted by the Intermediary.

We believe another reason for the untimely processing of credit balances is related to the fact that the Intermediary performs limited monitoring of hospital credit balances and does not review hospital credit balance procedures during its field audits of hospital Medicare cost reports.

Intermediary provider auditors, as part of their field audits of hospital cost reports, are instructed to review a hospital's policy related to MSP and the Medicare credit balance listings for outstanding inpatient and outpatient claims. This review was to be accomplished by sampling the listing and obtaining explanations for the credit balances. Identified MSP overpayments are to be referred to the Intermediary's MSP unit for resolution. However, we found that the most recent audits of the eight hospitals reviewed did not include an evaluation of hospital procedures over Medicare credit balances. As a result, the Intermediary did not have assurance that the hospitals routinely review their credit balances and refund overpayments in a timely manner.

Intermediary personnel informed us that budget and time constraints have caused them to put a low priority on any review of hospital credit balances. In addition, Intermediary personnel indicated that this issue is not given audit priority because it has a relatively small overall financial effect on hospital costs.

HCFA Recovery Project

Although little had been done to recover Medicare overpayments prior to our hospital audits, we found that the Intermediary and hospitals were beginning to take some corrective action on outstanding credit balances. In this regard, we noted a series

of correspondence from HCFA beginning in May 1991, in which HCFA established an overpayment recovery project, requiring hospitals to return all outstanding Medicare overpayments to the Intermediary. At the time of our review at the Intermediary, we were able to examine credit balance listings from five of the eight sampled hospitals. The reported amounts on these listings were generally higher than our projected amounts.

We were also able to identify the Medicare overpayments for the remaining 7 hospitals in our universe of 15 hospitals through reports sent by the hospitals to the Intermediary. Based on these reports, we noted that an additional $1.6 million in overpayments were due from these hospitals as follows:

Hospital	Medicare Credit Balances Per Hospital
Bristol	$2,317
Backus	182,311
Middlesex Memorial	287,350
Waterbury	98,503
Lawrence & Memorial	63,562
St. Raphael's	860,244
Bridgeport	70,129
Total	$1,564,416

Our review showed that the Intermediary is now taking action to process these outstanding overpayments resulting in recoupments to the Medicare program. However, we believe procedural improvements for the day-to-day processing of Medicare credit balances are needed at the hospitals and at the Intermediary to assure that all Medicare overpayments are identified and refunded timely.

RECOMMENDATIONS

Accordingly, we recommend that the Intermediary:

1. Reemphasize to the hospitals to report and refund all credit balances within a reasonable time frame (60 days).

2. Establish internal control procedures, including a focal point within the Intermediary, for reprocessing credit balance adjustments within required time frames.

3. Require provider auditors to review hospitals' compliance with credit balance requirements during their field audits.

4. Process adjustments for all outstanding credit balances identified in our detailed review of the eight sampled hospitals (projected to be about $1.3 million).

5. Review and process the $1.6 million in outstanding overpayments reported by the other seven hospitals not included in our sample.

Auditee's Comments

In response to our draft report, Intermediary officials generally agreed with our overall conclusions and recommendations. Their responses are summarized below.

Intermediary officials indicated that they will reemphasize to its providers to return Medicare overpayments to the Intermediary within 60 days of their identification. As part of this effort, the Intermediary will be reissuing provider instructions on proper handling of credit balances.

The Intermediary also intends to tighten controls and further coordinate the credit balance adjustment process by combining the primary and secondary claims processing units and the inpatient and outpatient units.

In response to our third recommendation, the Intermediary stated that the provider audit group is now required to review credit balances beginning with audits of providers' fiscal year ended September 30, 1989 cost reports. The Intermediary officials agreed that it placed a low priority on reviews of credit balances. However, the Intermediary indicated that this was due to limited funding from HCFA for the provider audit function and also because credit balance amounts have a relatively small overall financial effect on hospital costs. In spite of funding cutbacks from HCFA, the Intermediary plans to continue limited credit balance reviews at providers.

The Intermediary stated that it has adjusted credit balances totaling $3,855,085 in Calendar Year (CY) 1991 through the present for the eight hospitals sampled in our review. For the other seven hospitals in the review population, the Intermediary has recouped $3,076,394 during CY 1991.

In general, the Intermediary officials agreed with the three primary causes of credit balances identified in the report. The Intermediary cited the complexity of MSP regulations and start-up problems with the Common Working File and Arkansas claims processing system as contributors to their difficulties in processing credit balance adjustments. The Intermediary cited improvements in MSP monitoring and the resolution of start-up problems with their claims processing systems as efforts to reduce the incidence of outstanding credit balances.

Additional Office of Audit Services' (OAS) Comments

The Intermediary officials reported credit balance recoveries exceeding those identified in our report. The Intermediary's recoveries were related to a time frame which extended beyond the scope of our review.

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Final determination as to actions to be taken on all matters reported will be made by the HHS official named below. The HHS action official will contact you to resolve the issues in this audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at this time.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS' reports issued to the Department of Health and Human Services' (HHS) grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which HHS chooses to exercise (see title 45 Code of Federal Regulations, part 5).

To facilitate identification, please refer to Common Identification Number A-01-91-00515 in all correspondence relating to this report.

Sincerely yours,

Richard J. Ogden
Regional Inspector General
for Audit Services

APPENDICES - as stated

Direct Reply To:

Norma E. Burke
Associate Regional Administrator
Division of Medicare
Health Care Financing Administration
Room 1301, JFK Federal Building
Boston, Massachusetts 02203

APPENDICES

SCHEDULE OF MEDICARE CREDIT BALANCES
AT SELECTED CONNECTICUT HOSPITALS

Hospital	Report CIN	Inpatient Overpayments	Outpatient Overpayments
Stamford	A-01-91-00517	$333,937	$113,805
Norwalk	A-01-91-00521	256,057	48,609
Yale-New Haven	A-01-91-00519	93,957	171,410
Griffin	A-01-91-00524	39,745	54,727
Danbury	A-01-91-00522	48,058	33,507
Greenwich	A-01-91-00518	22,375	37,370
St. Vincent's	A-01-91-00520	17,131	18,938
St. Mary's	A-01-91-00523	9,134	17,152
Total		$820,394	$495,518

Note:

The amounts listed above are lower bounds and there is a 95 percent probability that the overpayment is at least the amount stated for each hospital.

Blue Cross
Blue Shield
of Connecticut

Federal Medicare
Intermediary

370 Bassett Road
North Haven, Connecticut 06473-4201
203/239-4911

February 18, 1992

Mr. Richard J. Ogden
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region 1
John F. Kennedy Federal Building
Boston, MA 02203

RE: Common Identification Number A-01-91-00515
Medicare Credit Balances

Per your request, we are responding to the results of your audit of the processing of outstanding Medicare Credit Balances by Blue Cross and Blue Shield of Connecticut.

Attached are listed your recommendations with our comments as well as our overall general comments.

Please contact me at (203) 630-4971 if you have any questions.

Sincerely,

Daniel J. Cyr
Director
Government Programs

DJC:jm

Attachment

cc: Norma Burke

Page 1

RECOMMENDATION 1:

"Re-emphasize to the hospitals the requirements to report all credit balances within the 60 day time frame included in the Medicare regulations." 1

Comments:

We are re-issuing our Medicare Bulletin to re-emphasize the Medicare regulation at 42 Code of Federal Regulations (CFR), part 489.20 (h), which requires providers to return Medicare overpayments to the Intermediary within 60 days of its identification.

Our Bulletin will re-emphasize that providers must have procedures in place to review and process Medicare credit balances and that these procedures must be implemented to ensure the 60 day time frames required by Federal Regulations.

In addition, we will re-emphasize the regulation found in the Federal Register, Vol. 54, No. 195/Wednesday, October 11, 1989, Part 489-Provider Agreements Under Medicare that the provider agrees "to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented. We will also re-issue our instruction that hospitals refer to their Hospital Manual (HIM 10), Section 300, which pertains to eligibility, and to Section 301 Identifying Other Primary Payers During the Admission Process.

We will also re-issue the definition of a Medicare credit balance as defined in the Health Care Financing Administration's BPO-F12 dated July 5, 1991 and OIG's Intermediary letter dated January 17, 1992.

RECOMMENDATION 2:

"Establish procedures, including a focal point within the Intermediary, for reprocessing credit balance adjustments within required time frames."

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1 This regulation pertains to MSP situations. However, 60 days is a reasonable time limit to refund all types of overpayments.

Comments:

Credit Balance adjustments are processed in the Medicare Claims Department which consists of primary and secondary processing units. The procedure for the identification of Medicare Secondary Payer (MSP) credit balances differs from the primary credit balance identification process due to MSP Federal regulations which mandate other payer identification, MSP reporting, and maintaining of MSP control files for each of the five basic MSP categories. Regardless of the different procedures for identifying credit balances, both primary and secondary processors maintain cooperation and coordination to ensure the timely identification and processing of Medicare overpayments.

We have reviewed OIG's recommendation and have ensured tighter controls and coordination by restructuring and combining the primary unit and the secondary unit. We have also combined the inpatient and outpatient units to facilitate processing credit balances caused by duplicate payments. The Arkansas processing system accepts hard copy UB-82 adjustment claim forms only. The adjustments are sorted and distributed to the appropriate unit for processing. The processors in the combined unit are assigned to specific providers and their adjustments are tracked from the time they are requested through payment when adjustments are made to the provider. The department supervisors are instructed to verify that all adjustments are complete. Tracking is both electronic and manual.

At the time of the OIG on-site review, the Medicare Claims Department as well as the Medicare Administration Department were coordinating HCFA's Overpayment Recovery Project which required all our providers to submit, by July 31, 1991, a report identifying all credit balances appearing on their records through March 31, 1991 as well as submitting corresponding checks and UB-82 claim forms. Consequently, both units were simultaneously working with OIG credit balances from the 8 sampled hospitals as well as HCFA's overpayment recovery project.

Our procedures for identifying and processing adjustment claims were in place at the time of OIG's on-site review. The adjustment procedures for both the MSP and primary units were distributed to the OIG auditors at this time.

RECOMMENDATION 3:

"Require provider auditors to review hospitals' compliance with credit balance requirements during their field audits."

Comments:

Our provider auditors (Medicare Cost Report Auditors) have been required to review the Hospitals Medicare Credit balances during their cost report audits beginning with the providers' FYE 9/30/89 audits. This was done in accordance with Section 'J' of our cost report audit program, and HCFA's UNICEP (HCFA Pub. 23-2) review program of our cost report audits.

It must be noted that the current HCFA reviews of our Medicare Audit function under UNICEP (HCFA-Pub. 23-2) have eliminated any review of Medicare Credit Balances. In addition, HCFA has been attempting to streamline the audits, pursue limited on site reviews of 40 hours, and in general reduce the audit budgets. At a recent Tri-Region meeting of Blue Cross Intermediaries, the review of Medicare Credit Balances by the Medicare Auditors is being revaluated.

On page 6 of OIG's draft report, it was noted that our Medicare Cost Report Auditors place a low priority on the review of the hospitals' credit balances due to budget and time constraints. This is basically true as the limited funding HCFA provides for cost report audits must first be utilized to satisfy HCFA's provider audit CPEP requirements of which credit balance reviews are not a part of . It was also noted that the Medicare Cost Report Auditors gave credit balance a low priority as it has a relatively small overall financial effect on hospital costs. This is also true as we are required to obtain an audit savings ratio on hospitals of 13 to 1. In addition, the cost report is required to be adjusted to PS&R data; therefore, any credit balances to be collected could not be reflected on the Medicare Cost Report by the auditors.

In summary, we are not convinced that HCFA intends to have the Medicare Cost Report Auditors review compliance with credit balance requirements based on their current review and funding practices. We will however, at this time, continue to have the auditors review the Hospitals' credit balances and include a limited review of the hospitals' compliance with credit balance requirements.

RECOMMENDATION 4:

"Process adjustments for all outstanding credit balances identified in the detailed review of the eight sampled hospitals (projected to be about 1.3 million)."

Comments:

Medicare has adjusted a total amount of $3,855,085 during the calendar year 1991 to the present for the 8 sampled hospitals. Medicare's individual adjustment amounts for the 8 hospitals exceeded the individual credit balance amounts identified by OIG for each hospital.

The total adjustment amount of $3,855,085 was processed through hard-copy UB-82 claim forms, deposits of provider checks, and through Medicare Cost Report settlement by utilizing PS&R data.

RECOMMENDATION 5:

"Process the $1.6 million in outstanding overpayments reported by the other seven hospitals not included in the sample."

Comments:

Medicare has adjusted a total amount of $3,076,394 during the calendar year 1991 for the 7 hospitals not included in the sample. Medicare's individual adjustment amounts for the 7 hospitals exceeded the individual credit balance amounts identified by OIG for each hospital.

The adjustment amount of $3,076,394 was processed through hard-copy UB-82 claim forms and the deposit of provider checks.

General Comments:

We agree with OIG's identification of three primary causes for Medicare overpayments, i.e., Medicare Secondary Payer situations, duplicate billing situations, and services not performed situations.

Medicare Secondary Payer Situations:

"Both Medicare and another insurer mistakenly paid primary for the same service when Medicare should have paid secondary."

If Medicare is not informed of other payer primary responsibility prior to the original claim payment then the provider is required to notify Medicare of the duplicate liability situation within 60 days of the duplicate payment. This requirement puts primary responsibility on the provider to identify duplicate payment situations and to notify us as they occur. In addition, PART 489-PROVIDER AGREEMENTS UNDER MEDICARE, published in the Federal Register, Vol. 54, No. 195, October 11, 1989, requires providers to maintain a system that, during the admission process, identifies any primary payers other than Medicare, so that incorrect billing and Medicare overpayments can be prevented.

This requirement has been communicated to providers through Medicare Bulletins and on-site outreach training programs. PART 489 - PROVIDER AGREEMENTS UNDER MEDICARE is included in the MSP Training Manuals distributed to providers.

Medicare Secondary Payer (MSP) procedures for identification of possible Medicare secondary responsibility improved after the Common Working File (CWF) created an MSP auxiliary record capability for each beneficiary. Our recoveries so far this year exceed recoveries, for the same time period, last year. The new IRS/SSA/HCFA data match to be implemented during FY 1992 is expected to further improve our capability to identify possible Medicare secondary situations before the initial claim is paid.

Duplicate Billing:

"Hospitals billed for services in total and by component, for different service dates or procedure codes."

The Arkansas claims processing system which is maintained by Arkansas central maintenance in accordance with HCFA regulations does have a duplicate billing detection capability, as does the Common Working File (CWF). However, these capabilities are not yet sufficiently developed to identify all possible duplicate billing situations.

The futuristic Ambulatory Pricing Group (APG) reimbursement mechanism currently under development by HCFA should eventually reduce the duplicate payment problem by paying what is known as an outpatient DRG for outpatient services. This way duplicate payment should not occur even if duplicate billing goes undetected.

In the short term, we continue to require hospitals to notify us of credit balances occurring on Medicare claims and to identify them as MSP or just duplicate payments from Medicare. Providers can accomplish this by checking the payment source for all received payments.

In addition, Medicare is monitoring duplicate billing situations to identify those providers who have problems with duplicates. Potential abusive situations are referred to the Program Integrity Unit. Medicare also periodically issues Bulletins to providers addressing the duplicate billing situation.

Services Not Performed:

"Hospital billed in anticipation of a service being rendered. The service was later cancelled."

This situation occurs when a hospital submits a bill based upon physician orders without taking the time to verify that the service was actually performed. Such instances are usually corrected by the provider.

In addition, our Medicare beneficiary community has played an active role in identifying those dates of service which were not performed. These situations are referred to our Program Integrity Unit.

The OIG audit results indicated that hospital officials have attempted in some cases to return overpayments to the Intermediary "but the adjustments were never processed by the Intermediary." In this regard, some of the hospitals responding to the OIG audit reports provided comments such as the "... the Intermediary did not act on our numerous requests to resolve these accounts..." and "The hospital has, in the past, tried to return Medicare credit balances to our Fiscal Intermediary...".

The Medicare Claims Department has experienced well-documented difficulties processing adjustments through the Common Working File (CWF). Many adjustments have been held up for extended periods of time. The problems we experienced were beyond our control and experienced by all Medicare Intermediaries. In October of 1991, Northeast CWF held a regional meeting to review adjustment processing problems and CWF distributed a voluminous book containing instructions for working with several of the worst problem edits. We have followed the issued processing guidelines and have made significant progress toward resolving our outstanding adjustment problems. However, some problems still remain unresolved. We are continuing to make progress on these by sending requests for assistance to the CWF staff.

A contributing factor to the hospitals' perception of attempting "to return credit balances to the Intermediary with limited responses..." lies in the complexity of the MSP program and corresponding regulations. We experience situations where the hospital insists that an MSP credit balance exists, when in fact, the credit balance appearing on their records is not a Medicare credit balance. Medicare paid correctly as the primary payer per Medicare regulations.

We recognize the complexities of MSP and continue our efforts to communicate and educate the health care community through telephone and written correspondence as well as the issuance of Medicare Bulletins.