OCT 30 2006

TO: Leslie V. Norwalk, Esq.
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Joseph E. Vengrin
Deputy Inspector General for Audit Services

SUBJECT: Review of Potential Duplicate Payments Identified by a Centers for Medicare & Medicaid Services Recovery Audit Contractor (A-03-06-00004)

The attached final report provides the results of our review of potential duplicate payments identified by a Centers for Medicare & Medicaid Services (CMS) recovery audit contractor (RAC). During our audit of the Hospital Payment Monitoring Program (report number A-03-05-00007), CMS advised us that its RACs had identified potentially duplicate claim payments during the review process. CMS reviewed a small number of those payments and determined that most were adjustments, not duplicates. We stated that we would perform additional work in this area.

To identify Medicare underpayments and overpayments and to recoup overpayments for both Part A and Part B services, CMS established contracts with three RACs in California, Florida, and New York on March 28, 2005. The California RAC, PRG Shultz, reviewed Medicare inpatient hospital claims that were submitted by hospitals and paid by the fiscal intermediary, United Government Services, to determine whether the intermediary made any overpayments, particularly duplicate payments, for the same beneficiary stay.

Our objective was to determine whether claims that the RAC identified as part of CMS's demonstration project were duplicate payments.

None of the 241 claims that the RAC initially identified were duplicate payments. Of the 241 claims, 12 claims included overpayments, totaling $44,746, for six beneficiary stays with 1-day admissions and subsequent same-day readmissions. The remaining 229 claims were routine claims and adjustment transactions that were paid correctly and did not involve duplicate payments.

During our review, the RAC and CMS directed the fiscal intermediary to adjust five beneficiary stay payments, which were made to California providers, and the fiscal intermediary recovered $38,338. The intermediary's medical director indicated that consolidating the two admissions as a single claim was appropriate medical practice. The RAC was not authorized to request an adjustment for the remaining overpayment because it was to a Hawaii provider; the RAC contract covered only California providers. However, as a result of our review, CMS directed the fiscal intermediary to adjust the payment and collect the $6,408 overpayment for the remaining beneficiary stay.

We recommend that CMS consider the performance of the RAC when reporting to Congress on the demonstration project's impact on Medicare savings and on CMS's decision to expand the project.

In its comments on our draft report, CMS concurred with our recommendation.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Lori Pilcher, Assistant Inspector General for Financial Management and Regional Operations, at (202) 619-1157 or through e-mail at Lori.Pilcher@oig.hhs.gov. Please refer to report number A-03-06-00004 in all correspondence.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF POTENTIAL DUPLICATE PAYMENTS IDENTIFIED BY A CENTERS FOR MEDICARE & MEDICAID SERVICES RECOVERY AUDIT CONTRACTOR

Daniel R. Levinson
Inspector General

October 2006
A-03-06-00004

Office of Inspector General

http://oig.hhs.gov

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The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Secretary of the Department of Health and Human Services to conduct a demonstration project up to 3 years in length to identify Medicare underpayments and overpayments and to recoup overpayments for both Part A and Part B services. To implement the project, the Centers for Medicare & Medicaid Services (CMS) established contracts with three recovery audit contractors (RAC) in California, Florida, and New York on March 28, 2005. Six months after completion of the project, approximately September 30, 2008, CMS must report to Congress on the project's impact on Medicare savings and whether to extend or expand the project.

The California RAC, PRG Shultz, reviewed Medicare inpatient hospital claims that were submitted by California and Hawaii hospitals and paid by the fiscal intermediary, United Government Services, to determine whether the intermediary had made any overpayments, particularly duplicate payments, for the same beneficiary stay.

OBJECTIVE

Our objective was to determine whether claims that the RAC identified as part of CMS's demonstration project were duplicate payments.

SUMMARY OF FINDING

None of the 241 claims that the RAC initially identified were duplicate payments. Of the 241 claims, 12 claims included overpayments, totaling $44,746, for six beneficiary stays with 1-day admissions and subsequent same-day readmissions. The remaining 229 claims were routine claims and adjustment transactions that were paid correctly and did not involve duplicate payments.

During our review, the RAC and CMS directed the fiscal intermediary to adjust five beneficiary stay payments, which were made to California providers, and the fiscal intermediary recovered $38,338. The adjustment required the fiscal intermediary to cancel the 1-day admission, combine the billed charges from the 1-day and same-day claims (less the room charge from the 1-day stay), and calculate the payment as a single claim. The fiscal intermediary's medical director indicated that consolidating two admissions as a single claim was appropriate medical practice. The RAC was not authorized to request an adjustment for the remaining overpayment because it was to a Hawaii provider; the RAC contract covered only California providers. However, as a result of our review, CMS directed the fiscal intermediary to adjust the payment and collect the $6,408 overpayment for the remaining beneficiary stay.

RECOMMENDATION

We recommend that CMS consider the performance of the RAC when reporting to Congress on the demonstration project's impact on Medicare savings and on CMS's decision to expand the project.

CENTERS FOR MEDICARE & MEDICAID SERVICES'S COMMENTS

In its comments on our draft report, CMS concurred with our recommendation. CMS's comments are included as the Appendix.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Medicare Program

Title XVIII of the Social Security Act established Medicare as a broad health insurance program that covers persons 65 years of age and older and those under 65 who are disabled or who have end-stage renal disease. Medicare Part A covers inpatient hospital care. The Centers for Medicare & Medicaid Services (CMS) administers the Part A program through contractors called fiscal intermediaries. United Government Services, a fiscal intermediary, processes and reimburses providers for inpatient hospital claims in California and Hawaii.

Recovery Audit Demonstration Project

Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 requires the Secretary of the Department of Health and Human Services to conduct a demonstration project up to 3 years in length to identify Medicare underpayments and overpayments and to recoup overpayments for both Part A and Part B services. To implement the project, CMS established contracts with three recovery audit contractors (RAC) in California, Florida, and New York on March 28, 2005. Six months after completion of the project, approximately September 30, 2008, CMS must report to Congress on the project's impact on Medicare savings and whether to extend or expand the project.

The California RAC, PRG Shultz, reviewed Medicare Part A inpatient hospital claims that were submitted by California and Hawaii hospitals and paid by the fiscal intermediary, United Government Services, to determine whether the intermediary made any overpayments, particularly duplicate payments, for the same beneficiary stay.

Inpatient Prospective Payment System

Medicare Part A pays hospitals for Medicare inpatient stays using a prospective payment system that includes a preestablished amount for each discharge based on a diagnosis-related group (DRG) code. In addition to the fixed DRG base payment, the Medicare payment may include outlier payments to help hospitals avoid large losses for extremely expensive cases.

An inpatient hospital discharge occurs when a Medicare beneficiary is either formally released from the hospital or dies in the hospital. Occasionally, a beneficiary will leave the hospital against medical advice and be readmitted later the same day.

When a fiscal intermediary receives a claim from a hospital, it performs consistency and utilization edits and calculates a payment. The fiscal intermediary sends the claim to the Common Working File for additional checks, including duplication of services.[1] When the claim has passed all edits in the Common Working File, the fiscal intermediary may pay the claim, reject the claim, or hold the claim until it obtains more information. CMS collects

[1]CMS implemented the Common Working File in 1991 to improve Medicare claims processing.

selected information from the Common Working File in the National Claims History File to evaluate and study the operation and effectiveness of the Medicare program.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether claims that the RAC identified as part of CMS's demonstration project were duplicate payments.

Scope

The audit covered the 241 claims with discharge dates occurring during fiscal years 2002–2004, for which the RAC initially identified potential overpayments totaling $11,305,633. The RAC provided the list of claims to the CMS project officer, who forwarded the list to the fiscal intermediary or quality improvement organization to verify that an overpayment existed. The CMS Program Integrity Group requested that we review those results. Accordingly, we reviewed the Common Working File's claims payment information to determine whether the fiscal intermediary paid those claims more than once. We limited our review of internal controls to CMS procedures for providing data to the RAC and CMS controls to prevent overpayments for Medicare inpatient hospital claims.

We performed our review from December 2005 through February 2006.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- interviewed CMS personnel regarding the accuracy and completeness of the claims data provided to the RAC;
- interviewed fiscal intermediary personnel regarding processing and payment procedures for 1-day admissions with a same-day readmission;
- reviewed the Common Working File claims data to determine whether the claims that the RAC identified were paid, canceled, or adjusted;
- identified the controls established by CMS, including processing edits in the Common Working File, and by the fiscal intermediaries to ensure that Medicare inpatient hospital claims were paid correctly; and
- verified the current claim payment status in the Common Working File for each of the 241 claims using the RAC's claim information and verified that the fiscal intermediary paid the claims correctly.

We performed our review in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATION

None of the 241 claims that the RAC initially identified were duplicate payments. Of the 241 claims, 12 claims included overpayments, totaling $44,746, for six beneficiary stays with 1-day admissions and subsequent same-day readmissions. The remaining 229 claims were paid correctly and did not involve duplicate payments.

During our review, the RAC and CMS directed the fiscal intermediary to adjust five beneficiary stay payments, which were made to California providers, and the fiscal intermediary recovered $38,338. The RAC was not authorized to request an adjustment for the remaining overpayment because it was to a Hawaii provider; the RAC contract covered only California providers. However, as a result of our review, CMS directed the fiscal intermediary to adjust the payment and collect the $6,408 overpayment for the remaining beneficiary stay.

During its validation of all potential duplicate payments that the RACs identified, CMS discovered that many of the potential overpayments were not actually duplicate payments. CMS realized that it had mislabeled the claim file provided to the RAC. Subsequently, CMS provided the RAC the correct claims data, which enabled the RAC to identify and adjust the five beneficiary stays with potential overpayments.

CLAIMS MISIDENTIFIED AS DUPLICATE PAYMENTS

The RAC provided the CMS Program Integrity Group with a list of 241 claim payments that purportedly identified original and duplicate (or triplicate) payments for the same beneficiary inpatient hospital stay. However, the fiscal intermediary had not made duplicate payments for any of the 241 claims.

Same-Day Admission Claims

Of the 241 claims reviewed, 12 claims, including 6 for a 1-day admission and 6 for the related same-day readmission, resulted in overpayments totaling $44,746. On each of the 1-day admissions, the beneficiary left the hospital against medical advice. Later on the date of the original admission and discharge, the hospital readmitted the beneficiary for the same or a related condition. This resulted in two claims for the same day.

Pursuant to 42 CFR § 412.4, hospitals are paid for inpatient claims under the prospective payment system when the beneficiary is either formally discharged from the hospital or dies in the hospital.

During our review, the RAC and CMS directed the fiscal intermediary to adjust five beneficiary stay payments, which were made to California providers, and the fiscal intermediary recovered $38,338. The adjustment process required the fiscal intermediary to cancel the 1-day admission, combine the billed charges from the 1-day and same-day claims (less the room charge from the 1-day admission), and calculate the payment as a single claim. The fiscal intermediary's medical director indicated that consolidating two admissions as a single claim was appropriate medical

practice. The RAC was not authorized to request an adjustment for the remaining overpayment because it was to a Hawaii provider; the RAC contract covered only California providers. However, as a result of our review, CMS directed the fiscal intermediary to adjust the payment and collect the $6,408 overpayment for the remaining beneficiary stay.

Routine Claims and Adjustment Transactions

The remaining 229 claims that the RAC initially identified as potential overpayments were actually routine claims and adjustment transactions that did not involve duplicate payments. The 229 claims included:

- 219 initial, interim, adjustment, or final claims;
- 8 unrelated inpatient hospital stay claims; and
- 2 no-payment claims.

MISLABELED CLAIMS INFORMATION

CMS provided data from the National Claims History file to the California RAC. That file included claim payments but did not include "reversal" claim information. Reversal claims are part of the adjustment claim process and reverse payments previously made for beneficiary claims. Based on discussions with CMS financial management personnel, the RAC incorrectly analyzed the claims data because it did not have all of the relevant claims information and incorrectly identified adjustment claims as duplicate payments because CMS initially provided the RAC incomplete claims information. During its validation process, CMS realized its mistake and provided the RAC with all claims transactions, including the reversal claims.

For the eight unrelated inpatient hospital stay claims identified with different admission and discharge dates, it appears that the RAC inadvertently identified the claims as potential duplicates because in all four cases, the patient was readmitted to the hospital on the same month and date, but in a different year.

CMS stated that it now provides all claims data, including adjustments, to the RACs. According to CMS, once the RACs reviewed all claims data, including adjustments, they were able to identify five claim overpayments correctly.

RECOMMENDATION

We recommend that CMS consider the performance of the RAC when reporting to Congress on the demonstration project's impact on Medicare savings and on CMS's decision to expand the project.

CENTERS FOR MEDICARE & MEDICAID SERVICES'S COMMENTS

In written comments on our draft report, CMS concurred with our recommendation and provided an update on the results of the RAC demonstration project. CMS's comments are included as the Appendix. CMS also provided technical comments, which we incorporated in our final report as appropriate.

APPENDIX

APPENDIX

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: OCT 2 2006

TO: Joseph E. Vengrin
Deputy Inspector General for Audit Services

FROM: Mark B. McClellan, M.D., Ph.D.
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Review of Potential Duplicate Payments Identified by a Centers for Medicare & Medicaid Services Recovery Audit Contractor (A-03-06-00004)

Thank you for an opportunity to comment on the results of your review. The Centers for Medicare & Medicaid Services (CMS) concurs with the OIG's recommendation to consider the performance of the Recovery Audit Contractors (RACs) when we issue our final report to Congress. The CMS is carefully evaluating the results of the demonstration and its potential value to the Medicare program, and the results indicate important progress in eliminating improper payments in Medicare.

I welcome this opportunity to update the OIG on the RAC demonstration. The RAC demonstration has shown that recovery audit contractors can succeed in Medicare. In addition, we are satisfied with the knowledge of Medicare policies demonstrated by the RACs and the communication between the Medicare provider communities and the RACs. Moreover, our early work validating the RACs' findings helped strengthen the process without causing undue hardship to health care providers.

Consequently, the CMS is satisfied with the work of the California RAC. PRG Schultz, as well as all of the RACs have an open relationship with the medical and hospital associations in the states and continue to strive to improve its Medicare recovery process. PRG Schultz has correctly identified many Medicare overpayments and CMS is confident this information will lead to less improper payments in the future. We are confident that the data we collect, the statistics we prepare, and the feedback we receive will be representative of the RACs' capabilities and the potential value they may offer.

CMS welcomes the interest by the OIG in the RAC demonstration and will continue to work with you to provide necessary updates. Enclosed please find technical comments and suggestions regarding the complete text of the report.

ACKNOWLEDGMENTS

This report was prepared under the direction of Stephen Virbitsky (Regional Inspector General for Audit Services). Other principal Office of Audit Services staff who contributed include:

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