DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date DEC 21 1992

From Bryan B. Mitchell
Principal Deputy Inspector General

Subject Update on Findings Developed in Our National Review of Medicare Beneficiary Accounts With Credit Balances (A-03-92-00010)

To

William Toby, Jr.
Acting Administrator
Health Care Financing Administration

Attached is a copy of a management advisory report (MAR) entitled, "Update on Findings Developed in Our National Review of Medicare Beneficiary Accounts With Credit Balances." This report updates the findings that were previously reported in a MAR issued to the Health Care Financing Administration (HCFA) and recommends additional action.

On August 29, 1991, we issued a MAR to HCFA in which we first reported the results of our pilot review of Medicare beneficiary accounts with credit balances at 11 hospitals and 1 intermediary. We reported that eight of the hospitals were not reviewing these accounts to determine if there were Medicare overpayments that should be refunded to the intermediary. Instead, the eight hospitals kept the overpayments and the intermediary failed to detect the error.

We reported that we were expanding our review of Medicare credit balance accounts nationally. We recommended interim measures that HCFA require intermediaries to review Medicare beneficiary accounts with credit balance accounts during hospital audits, and that it monitor intermediaries' compliance with this audit requirement. The HCFA agreed to implement our recommendations and instituted recovery action.

The results of our expanded review at 76 hospitals and 9 intermediaries show that the conditions reported in our initial MAR are national in scope. Based on statistical sampling techniques, we estimate that hospitals owe the Medicare program $266.4 million.

We have also identified two issues that were not addressed in our previous MAR. One deals with intermediaries failure to recover Medicare overpayments even when hospitals attempted to refund them. The other issue involves some hospitals writing

off Medicare beneficiary accounts with credit balances from their accounting records, and keeping the Medicare overpayments.

These findings were not included in our prior MAR, nor reflected in our previous recommendations. We believe that they must be addressed if HCFA is to ensure that Medicare overpayments made to hospitals are refunded to the program. We recommend that HCFA: (1) continue its recovery efforts as outlined in its instructions to intermediaries; and (2) supplement these instructions by requiring intermediaries to respond timely to hospitals' attempts to refund Medicare overpayments, and to include in their hospital audits a review of Medicare beneficiary accounts with credit balances that were written off by the hospitals.

The HCFA's response was again favorable and swift. The HCFA implemented the recommendations and reported that about $171.6 million in Medicare overpayments had been identified, and that about $84.1 million had been recovered. As of June 30, 1992, those amounts had grown to $326.5 million in Medicare overpayments identified and $194.1 million recovered.

We would appreciate being advised, within 60 days, of any additional actions taken or planned on our recommendations. If you wish to discuss our report, please let me know or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 966-7104. Copies of this report are being sent to other interested Department officials.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

UPDATE ON FINDINGS DEVELOPED IN OUR NATIONAL REVIEW OF MEDICARE BENEFICIARY ACCOUNTS WITH CREDIT BALANCES

DECEMBER 1992 A-03-92-00010

DEPARTMENT OF HEALTH & HUMAN SERVICES

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Principal Deputy Inspector General

Subject Update on Findings Developed in Our National Review of Medicare Beneficiary Accounts With Credit Balances (A-03-92-00010)

To

William Toby, Jr.
Acting Administrator
Health Care Financing Administration

This management advisory report (MAR) is to provide you the results of our national review of Medicare beneficiary accounts with credit balances at 76 hospitals and 9 intermediaries.

On August 29, 1991, we issued a MAR to the Health Care Financing Administration (HCFA) on the preliminary results of our pilot review of Medicare beneficiary accounts with credit balances at 11 hospitals served by 1 intermediary. We concluded that 8 of the 11 hospitals were not reviewing all of these accounts to determine if they had received Medicare overpayments. Instead, the eight hospitals kept Medicare overpayments and the intermediary (Independence Blue Cross) failed to detect the error.

We recommended that HCFA: (1) require intermediaries to review Medicare beneficiary accounts with credit balances during hospital audits and (2) review intermediaries' compliance with the audit requirement. We also reported that, as a result of this pilot study, we had expanded our review nationally to additional hospitals and intermediaries.

The results of our expanded review at the 76 hospitals and 9 intermediaries show that the conditions reported in our initial MAR are national in scope. Based on statistical sampling techniques, we estimate that hospitals owe the Medicare program $266.4 million.

Furthermore, we have identified two issues that were not addressed in our previous MAR to HCFA. First, the intermediaries did not always respond to attempts made by hospitals to refund Medicare overpayments to the program. Second, at least five hospitals wrote-off Medicare beneficiary accounts with credit balances without refunding Medicare overpayments to the intermediaries.

The recommendations in our previous MAR did not specifically address the new issues brought to light in this report. We, therefore, believe that HCFA needs to (1) continue its recovery efforts; and (2) supplement its instructions to the intermediaries by requiring them to respond timely to all attempts by hospitals to refund Medicare overpayments, and to include in their hospital audits a review of all Medicare beneficiary accounts with credit balances written off by the hospitals so that Medicare overpayments included in these accounts can be refunded to the program.

The HCFA response to our prior MAR was very favorable. The HCFA agreed to implement our recommendations, and instructed all intermediaries to require hospitals to report their Medicare credit balances[1] on a quarterly basis. The HCFA, however, had to temporarily suspend the mandatory Medicare credit balance reporting requirement pending approval from the Office of Management and Budget (OMB).

The HCFA's responses to both OIG reports have been quick and effective. As of June 30, 1992, HCFA identified $326.5 million in Medicare overpayments and recovered $194.1 million.

In a memorandum dated July 28, 1992, HCFA responded to a draft of this report. The HCFA agreed with both recommendations and reported that it has issued the necessary instructions to intermediaries and providers to implement them. The HCFA also reported that OMB had approved the mandatory reporting requirements, and recovery efforts were underway. By March 1992, providers had reported Medicare credit balances, that is, Medicare overpayments, of $171.6 million, and $84.1 million of that amount had been repaid. As of June 30, 1992, those amounts had grown to $326.5 million in Medicare overpayments identified and $194.1 million recovered. Additional recoveries are anticipated as a result of the renewed reporting efforts.

We have summarized HCFA's response at the end of this report and have attached the entire response to this report as Appendix D.

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[1]The HCFA defines a Medicare credit balance as a credit balance payable to the Medicare program, in other words, a Medicare overpayment.

BACKGROUND AND AUDIT METHODOLOGY

A credit balance in a Medicare beneficiary account occurs when a hospital records a higher reimbursement than the amount charged for the beneficiary. A credit balance may be due to an accounting error or to an overpayment by an intermediary. Hospitals must review each of these accounts to determine if the credit balance was caused by a Medicare overpayment that should be refunded to the intermediary.

The objectives of our review were (1) to determine if hospitals are reviewing Medicare beneficiary accounts with credit balances to identify Medicare overpayments, (2) to determine if hospitals are refunding Medicare overpayments to their intermediary, and (3) to evaluate the intermediaries' oversight controls over hospitals' handling of Medicare beneficiary accounts with credit balances.

Our national review of Medicare beneficiary accounts with credit balances is being conducted at 9 intermediaries and 76 hospitals. We began our review by judgementally selecting 1 intermediary and randomly selecting 11 hospitals serviced by this intermediary. Upon deciding to expand our review nationally, we randomly selected 8 additional intermediaries that serviced 8 or more hospitals with more than 200 beds. We then randomly selected 8 hospitals (with more than 200 beds) serviced by each of the 8 intermediaries. Finally, we judgementally selected one hospital at one of the intermediaries previously selected because of the possibility that this hospital was writing off Medicare beneficiary accounts with credit balances. We did not include in any of our projections the results of our review at the one hospital that we judgementally selected. This hospital is undergoing continued Office of Inspector General (OIG) review.

Therefore, the projections in this report are made by (1) projecting the results of our reviews at the 75 randomly selected hospitals to their respective intermediaries, (2) projecting the results of our review at the eight randomly selected intermediaries to the universe of intermediaries excluding the one intermediary judgementally selected, and (3) adding to this projection the projected results at the 1 intermediary that was judgementally selected. Therefore, our projections are based on our reviews at 75 hospitals and 9 intermediaries.

We have issued audit reports to the 75 hospitals and are in the process of issuing reports to the intermediaries.

RESULTS OF REVIEW

The results of our review show that the conditions first reported at eight hospitals and one intermediary are national in scope. Seventy-one of the randomly selected 75 hospitals included in our review had not refunded Medicare overpayments to their intermediary. The overpayments at the 71 hospitals totaled $8.5 million (Appendix A). We projected these results to the nine intermediaries that service the hospitals and estimated that the intermediaries had not collected an estimated $55.6 million in Medicare overpayments from all hospitals that they service (Appendix B). This consists of $54.4 million owed by hospitals serviced by the eight randomly selected intermediaries, and $1.2 million owed by hospitals serviced by the one intermediary judgementally selected.

Using these results, we projected our results to all intermediaries (with 8 or more hospitals with over 200 beds) and estimated that hospitals owe the Medicare program $266.4 million (Appendix C). We also aged the Medicare overpayments included in our statistical sample from the time that the credit balance in the beneficiary's account was first recorded to the date of our review. Based on this aging, we estimated that, without effective HCFA intervention, Medicare overpayments could increase by as much as $159 million per year in the future.

Causes For Medicare Overpayments

We reviewed hospital and intermediary records and determined that there were several causes for Medicare overpayments being made to hospitals. Most of the overpayments, however, could be traced to hospital billing practices. We projected the results of this segment of the review to the point estimate of $266.4 million as shown below.

- Overpayments of $113.1 million, or 42.4 percent, were caused by hospitals billing Medicare and a private insurer for the same service, being reimbursed by both, and keeping both payments. Regulations governing the Medicare Secondary Payer program state that Medicare will not reimburse for services if the services are

covered by another insurer. The regulations also require a recipient of a third-party payment who has also received a Medicare conditional payment, to refund Medicare's payment within 60 days.

- Overpayments of $98.4 million, or 36.9 percent, were caused by hospitals submitting duplicate billings for services. Most of the claims went undetected by intermediaries because hospitals used different procedure codes, or dates of service for the same service.

- Overpayments of $19.3 million, or 7.3 percent, were caused by hospitals billing for services not performed. Usually this occurred when hospitals mistakenly anticipated that a service would be performed, but was not because of some unforseen circumstance. When the hospitals became aware that the service was not performed, they canceled the charges, thus creating a credit balance in the Medicare beneficiary's account.

- Overpayments of $12.9 million, or 4.8 percent, were caused by miscellaneous errors made, for the most part, by intermediaries. For example, we found errors in calculating the deductibles and co-insurance amounts, and payments made for noncovered services.

- Overpayments of $6.6 million, or 2.5 percent, were caused by the hospitals billing for an outpatient service that was included in a beneficiary's inpatient claim. Medicare regulations require that any outpatient service performed within a certain number of hours prior to an admission is to be included on the inpatient bill.

- Overpayments of $16.1 million, or 6.1 percent, were caused by errors not identified. There were numerous instances where hospitals lacked sufficient information for us to determine the cause of Medicare credit balances. Since some of these credit balances were likely caused by Medicare overpayments, we projected our findings using the results of our review of all of the accounts for which sufficient information was available.

Causes of Overpayments Not Being Recovered

As indicated in our prior MAR, the primary reason these overpayments were not refunded to the intermediaries was that hospitals were not reviewing their Medicare beneficiary accounts with credit balances to determine if the credit balances were caused by Medicare overpayments. However, subsequent to the issuance of that MAR, we determined that intermediaries were not always recovering overpayments even when hospitals attempted to refund them. Fifty-two of the hospitals included in our review unsuccessfully attempted to refund some Medicare overpayments to eight of the nine intermediaries. The hospitals identified the overpayments through review of their Medicare beneficiary accounts with credit balances.

We are concerned that the intermediaries' failure to respond to the hospitals' efforts to refund Medicare overpayments can be misinterpreted by the hospitals as a disincentive to identifying additional Medicare overpayments for subsequent return to the intermediaries. We are currently reviewing the intermediaries' policies and procedures to determine why they did not recover the Medicare overpayments reported by the hospitals. Preliminary indications are that intermediaries are not placing a sufficiently high priority on recovering overpayments, believing that their primary function is to make payments. The results of this portion of our review will be reported separately.

Some Hospitals Wrote-Off Medicare Overpayments

Our results also show that at least five hospitals wrote-off their accounting records Medicare beneficiary accounts with credit balances, and kept the overpayments. This condition was first detected at a large nationally known hospital (Hospital).

The OIG has identified five hospitals that wrote-off Medicare beneficiary accounts with credit balances and kept the overpayments.

Hospital officials informed us that, as a matter of policy, the Hospital reviewed all Medicare beneficiary accounts with credit balances. For every identified Medicare overpayment, a notice of retraction was sent to the intermediary to initiate

recovery action. If the intermediary did not act on the retraction notice within 90 days, the credit balance was written off the accounting records, the refunding effort was discontinued, and the retraction notice was usually destroyed.

This policy is unacceptable and is under further review within the OIG. It allows the Hospital to destroy documentation (retraction notices) showing that at least a minimal effort was made to refund the identified overpayment to the intermediary. Destroying the retraction notices effectively damages the audit trail and hampers efforts of intermediary auditors and others to determine if the Hospital actually attempted to refund identified Medicare overpayments.

More importantly, however, this policy allows the Hospital to keep Medicare overpayments after they had been identified as such. During the period July 1, 1986 through June 30, 1991, the Hospital had written off 901 Medicare beneficiary outpatient accounts with credit balances, and 293 Medicare beneficiary inpatient accounts with credit balances over $1,000. These accounts totaled about $4.9 million. To determine the amount of Medicare overpayments included in these accounts, we randomly selected 100 outpatient accounts from $100 to $10,000, and 107 inpatient accounts from $1,000 to $30,000. In addition, we reviewed all 6 outpatient accounts over $10,000 and all 27 inpatient accounts over $30,000.

Of the 240 Medicare accounts reviewed, 143 contained Medicare overpayments. The intermediary had recovered the overpayments associated with only 6 of the 143 accounts. The Hospital was able to provide us with retraction notices for 20 of the 137 overpayments that were not recovered. It appears that the intermediary did not respond to the Hospital's attempt to refund the 20 overpayments.

Regarding the other 117 overpayments that were written off, the Hospital claimed that it had either reviewed the accounts and did not identify an overpayment, or, according to its policy, had sent retraction notices to the intermediary and destroyed them when the accounts were written off. While this may be so (the intermediary had no record of receiving the retraction notices), we noted that, of the 20 Medicare overpayments still listed on the Hospital's accounting records, the Hospital was able to provide only 9 retraction notices. This is an indication that the Hospital had not attempted to refund all Medicare overpayments to the intermediary.

We projected[2] the results of our review of Medicare beneficiary accounts with credit balances written off by the Hospital for both inpatient and outpatient accounts. The point estimate for inpatient overpayments written off was $1.1 million with a standard error of $79,221. The point estimate for outpatient overpayments was $293,559 with a standard error of $74,320 (this is not included in our national projection).

We have identified four other hospitals that also wrote-off Medicare beneficiary accounts with credit balances. The amounts written off were not nearly as significant as the amount written off by the Hospital. However, one of these hospitals wrote-off $261,593 in Medicare overpayments and kept the funds.

Conclusions and Recommendations

Our national audit is nearing completion. Audit reports have been issued to the hospitals included in this review. We are in the process of issuing consolidated reports to the intermediaries. Rather than awaiting the finalization of our reports, we chose to alert HCFA of pressing problems that require immediate attention.

Our initial report, issued on August 29, 1991, was met by HCFA's timely and aggressive response which adequately addressed all of the recommendations contained therein. However, new developments resulting from our ongoing review showed that additional HCFA action is necessary.

We determined that the intermediaries did not aggressively pursue recovery of some Medicare overpayments reported by 52 hospitals. We also determined that some hospitals wrote-off their accounting records Medicare beneficiary accounts with credit balances and kept all Medicare overpayments within these accounts. These findings were not included in our prior report, nor reflected in our previous recommendations. We believe that these findings must be addressed if HCFA is to ensure that Medicare overpayments made to hospitals are refunded to the program.

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[2]This projection was not included in our national projection of overpayments because credit balance accounts written off were not originally included in the scope of our audit.

We, therefore, recommend that HCFA:

1. Continue its plan of recovery by requiring hospitals to report Medicare credit balances (i.e. overpayments) to intermediaries on a quarterly basis. We estimate that recoveries should total about $266.4 million for hospitals with over 200 beds.

2. Supplement its previous instructions to intermediaries by requiring them to:

   a. Respond in a timely manner to all hospitals' attempts to refund Medicare overpayments that they identified through review of Medicare beneficiary accounts with credit balances.

   b. Include in their hospital audits a review of Medicare beneficiary accounts with credit balances that were written off by the hospitals. All identified Medicare overpayments should be refunded to the program.

HCFA Response and OIG Comments

The HCFA has, in its response to our draft report, agreed with both recommendations and stated that it has issued the necessary instructions to implement them. The HCFA also made four technical comments regarding (1) a suggested citation of a regulation, (2) the use of the term "Medicare credit balances," (3) the identity of the Hospital that wrote-off the Medicare overpayments, and (4) a discussion on the legality of writing off a Medicare overpayment.

In agreeing with our first recommendation, HCFA stated that, as of March 1992, providers had reported about $171.6 million in Medicare overpayments and about $84.1 million of these overpayments had been recovered. The HCFA also stated that OMB had approved the mandatory credit balance reporting requirements, and that the requirements had been reinstated. The first report, for the period ended June 30, 1992, showed that the amount of Medicare overpayments reported had grown to $326.5 million and the amount recovered to $194.1 million.

The HCFA also agreed with both parts of our second recommendation. Intermediaries and providers were notified that checks would be accepted as repayment of credit balances, and HCFA is developing an electronic system to process

adjustment claims so that overpayments can be recovered faster. Intermediaries were instructed to reduce pending adjustment claims to no more than a 2-month workload. The HCFA also instructed intermediaries to review provider compliance with the credit balance reporting requirements as part of the regularly scheduled cost report field audits. Intermediaries are also required to identify written off credit balances.

We believe these actions by HCFA will result in the timely recovery of Medicare overpayments. The renewed mandatory reporting requirements should increase the amount of Medicare overpayments reported by hospitals, and should increase the amount of Medicare recoveries from the current $84.1 million to our estimated amount of $266.4 million. Continued and effective implementation of our recommendations could result in additional recoveries of about $159 million per year in the future.

Regarding the technical comments made by HCFA, we have added the regulation citation suggested by HCFA and are providing under separate cover the name of the hospital referred to on page 6 of this report. We have neither identified the hospital in this report nor dealt with the "legality" of writing off Medicare beneficiary accounts with credit balances because the issue is still being reviewed within the OIG.

One of HCFA's technical comments pertained to the use of the term "Medicare credit balance." The HCFA stated that the OIG definition of a "Medicare credit balance" appears to be any credit balance appearing in a Medicare beneficiary's account, while its definition is a credit balance payable to the Medicare program. The HCFA suggested that we use its definition to avoid confusion.

The HCFA is correct. As used in our draft report, a "Medicare credit balance" did not necessarily mean a credit balance payable to the Medicare program. We pointed out in the draft report, and in this report as well, that hospitals had to review each "Medicare credit balance" to determine if the credit balance was caused by a Medicare overpayment. Our statistical sample showed that many of the "Medicare credit balances" were caused by overpayments, but some were caused by accounting errors.

The HCFA's definition of a Medicare credit balance is essentially a Medicare overpayment. To avoid any confusion with HCFA's definition, we have used in this report the term

"Medicare beneficiary accounts with credit balances." These accounts must be reviewed to identify Medicare overpayments or, as defined by HCFA, "Medicare credit balances" that must be reported quarterly to the intermediaries.

OTHER MATTERS

Subsequent to the issuance of our draft report, we had discussions with certain congressional staff who are interested in Medicare credit balances caused by hospitals simultaneously billing Medicare and other insurers. These staff members proposed a potential solution whereby hospitals providing care to Medicare beneficiaries who are also entitled to some other insurance would be required to bill the other insurance first and await reply before billing Medicare. Any subsequent bill to Medicare would be required to contain documentation evidencing the other insurer's action, i.e., full payment, partial payment or denial of payment. If the other insurer's payment decision did not accompany the Medicare bill, the Medicare payment would be automatically denied.

While the congressional staff's proposed solution would probably reduce the incidence of erroneous Medicare payments, other considerations must be evaluated before requiring a sequencing of bills (others first, Medicare second):

- Many Medicare beneficiaries have private Medigap policies which pay for the beneficiaries' share of covered Medicare services, i.e., coinsurance and deductible amounts. Many existing Medigap policies require beneficiaries to bill Medicare first and send Medicare's payment information, which is provided to the beneficiaries on Explanation of Medicare Benefits forms, to the private insurer for it to make the Medigap payment. Adoption of the congressional staff's proposal would require major revisions to many existing Medigap policies.

- Under current law and regulations, all bills must be submitted to Medicare no later than 27 months after care was provided to the beneficiary. This time frame would probably have to be extended in order to recognize the time other insurers will need to first process the claim. A study would be needed in order to determine a reasonable extension of the filing period.

- Extending the filing period would probably increase the costs incurred by Medicare intermediaries and carriers. For example, they would probably be required to store more data on claim histories (utilization) files. The costs associated with additional storage would be charged to Medicare's administrative cost budget.

- Adopting the congressional staff proposal would also probably disturb the current Medicare cash flow to providers. They will have to wait longer for Medicare payments.

The congressional staff's proposal cannot easily be dismissed since our audit showed that sizable Medicare overpayments occurred as a result of hospitals being able to simultaneously submit bills to Medicare and other insurers. Of course, the longstanding Medicare Secondary payer problems with identifying incorrect Medicare payments and then seeking repayment from an insurance company requires that all potential solutions be fully evaluated. However, more discussion is needed in order to evaluate our concerns and others that may emerge. We welcome HCFA's comments on the congressional staff suggestions as we continue our evaluation of this possible change in provider claims processing.

APPENDICES

SUMMARY RESULTS
BY
HOSPITAL

Intermediary / Hospital		Medicare Overpayment
1.	**Independence Blue Cross ***	
1.	St. Joseph's	$ 0
2	St. Agnes Medical Center	0
3.	Albert Einstein Medical Center	231,283
4.	Temple University	64,204
5.	Magee Rehabilitation	8,059
6.	Eagleville	0
7.	Lawndale Community	1,174
8	Warminister	244
9.	North Penn	14,096
10.	Delaware Valley Memorial	2,053
11.	Southern Chester	3,422
Intermediary Total		$ 324,535
2.	**Blue Cross and Blue Shield of Connecticut**	
12.	Yale New Haven	364,334
13.	Norwalk	386,857
14.	Danbury	81,565
15.	St. Vincent's Medical Center	36,070
16.	Greenwich Hospital Association	84,066
17.	St. Mary's	31,540
18.	Stanford	529,966
19.	Griffin	175,144
Intermediary Total		$1,689,542
3.	**Blue Cross and Blue Shield of New Jersey**	
20.	Atlantic City	94,622
21.	Overlook	142,486
22.	Christ	139,008
23.	United Hospital of Newark	76,521
24.	St. Clair Riverside Medical Center	30,228
25.	Our Lady of Lourdes Medical Center	246,656
26.	Kimball Medical Center	700,178
27.	Medical Center at Princeton	103,719
Intermediary Total		$1,533,418

* Intermediary judgmentally selected. The 11 hospitals serviced by this intermediary were randomly selected.

4.	**Blue Cross and Blue Shield of Maryland**	
28.	Johns Hopkins	$ 572,504
29.	Washington Hospital Center	227,465
30.	Harbor Hospital Center	284,024
31.	Suburban Hospital Association	36,432
32.	Anne Arundel General	8,170
33.	Washington County	63,593
34.	Liberty Medical Center	162,085
35.	Frederick Memorial	62,835
36.	The Hospital**	0
Intermediary Total		$1,417,108
5.	**Blue Cross and Blue Shield of South Carolina**	
37.	Spartenberg Regional Medical Center	15,568
38.	Baptist Medical Center at Columbia	294,846
39.	Roper	54,294
40.	Mc Leod Regional Medical Center	40,081
41.	St. Francis Xavier	70,578
42.	Trident Regional Medical Center	84,519
43.	Lexington Medical Center	34,912
44.	Tuomey Regional Medical Center	26,826
Intermediary Total		$ 621,624
6.	**Blue Cross and Blue Shield of Wisconsin**	
45.	Meriter	14,297
46.	St. Francis	245
47.	Sinai Samaritan	72,218
48.	Trinity Memorial	14,134
49.	Sacred Heart	0
50.	St. Catherines	34,966
51.	St. Lukes	31,035
52.	St. Jospeh's	7,661
Intermediary Total		$ 174,556
7.	**Blue Cross and Blue Shield of Michigan**	
53.	Henry Ford	301,324
54.	Sparrow	149,457
55.	Providence	243,178
56.	St. Jospeh's	144,231

** The Hospital is not identified and preliminary results are not included in this report because of an ongoing OIG review. The Hospital was judgmentally selected.

57.	Marquette General	$ 57,069
58.	Ingram Medical Center	13,155
59.	Hutzel	168,791
60.	Crittenton	37,929
Intermediary Total		$1,115,134
8.	**Blue Cross and Blue Shield of Oklahoma**	
61.	St Francis	191,684
62.	Baptist Medical Center of Oklahoma	38,968
63.	South Community	8,542
64.	Mercy Health Center	7,880
65.	Oklahoma Osteopathic	70,329
66.	Muskogee Regional Medical Center	10,386
67.	Jane Phillips Memorial Medical Center	9,870
68.	Deaconess Hospital	2,990
Intermediary Total		$ 340,649
9.	**Blue Cross of California**	
69.	University of California San Francisco	127,420
70.	St. John's Hospital and Health Center	130,189
71.	University of California San Diego	97,280
72.	Tri-City Medical Center	473,864
73.	Little Company of Mary Hospital	256,216
74.	Northridge Hospital and Medical Center	347
75.	Mission Hospital Medical Center	138,171
76.	Paralta	108,626
Intermediary Total		$1,332,113
TOTAL MEDICARE OVERPAYMENTS TO HOSPITALS		$8,548,679***

*** Only 71 of the 76 hospital had Medicare overpayments which they had not refunded.

SUMMARY RESULTS BY INTERMEDIARY

Intermediaries	Medicare Overpayments	
	Hospitals in Sample	All Hospitals
Independence Blue Cross*	$ 324,535	$ 1,249,179
Blue Cross/Blue Shield of Connecticut	1,689,542	3,167,889
Blue Cross/Blue Shield of New Jersey	1,533,418	14,950,789
Blue Cross/Blue Shield of Maryland	1,417,108	6,908,402
Blue Cross/Blue Shield of South Carolina	621,624	1,320,953
Blue Cross/Blue Shield of Wisconsin	174,556	741,867
Blue Cross/Blue Shield of Michigan	1,115,134	7,805,960
Blue Cross/Blue Shield of Oklahoma	340,649	681,298
Blue Cross of California	$1,332,113	18,816,251
Total	$8,548,679	$55,642,588

* Intermediary judgementally selected

SUMMARY OF STATISTICAL METHODOLOGY

INPATIENT CREDIT BALANCES

Audit Objective:

The objective of our audit is to determine if the hospitals and intermediaries reviewed are treating credit balances occurring in patient accounts in accordance with Medicare regulations, including the guidelines prescribed by HCFA. We limited our review to credit balances over $1,000.

Primary Sampling Population:

All the intermediaries across the country that serve at least 8 hospitals which have a capacity of 200 beds or more and handle Medicare claims.

Secondary Sampling Population:

All of an intermediary's Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and Prospective Payment System (PPS) hospitals on the intermediary's list of hospitals that were being serviced by the intermediary at the time the list was obtained.

(Note: The hospital must still be providing services in order to be eligible.)

Third-stage Universes of Credit Balances at Individual Hospitals:

A. Credit balances between $1,001 and $10,000, in the account of a Medicare patient, on the hospital's most recent inpatient Accounts Receivable Report.

B. Credit balances greater than $10,000, in the account of a Medicare patient, on the hospital's most recent inpatient Accounts Receivable Report.

Primary Sampling Unit: One intermediary

Secondary Sampling Unit: One hospital served by the selected intermediary.

SUMMARY OF STATISTICAL METHODOLOGY

Third-stage Sampling Units:

A. A credit balance between $1,001 and $10,000, in the account of a Medicare patient, on the hospital's most recent inpatient Accounts Receivable Report as of the date the audit begins.

B. A credit balance greater than $10,000, in the account of a Medicare patient, on the hospital's most recent inpatient Accounts Receivable Report as of the date the audit begins.

Survey and Background Information:

The sample populations are projected for two separate populations. One population is credit balances between $1,001 and $10,000 and the second population is the credit balances greater than $10,000.

The results of the point estimates are added for reporting purposes. The error for the populations are reported separately.

Sample Design:

A. Multistage Sampling for reporting results at the national level. (Three-stage)

B. Multistage Sampling for reporting results at the intermediary level. (Two-stage)

C. Simple random sampling for reporting the results at the hospital level.

Primary Sample Size: Eight intermediaries

Secondary Sample Size: Eight hospitals

Third-stage Sample Sizes:

A. Credit balances of 100 between $1,001 and $10,000.

B. All credit balances greater than $10,000.

Source of Random Numbers: Office of Audit Services Statistical Sampling Software.

SUMMARY OF STATISTICAL METHODOLOGY

Method of Selecting Primary Sample Items:

A. List all intermediaries in the sample frame alphabetically. Number the intermediaries from 1..N.

B. Randomly select eight intermediaries.

Method of Selecting Secondary Sample Items:

A. List all hospitals in the sample frame alphabetically. Number the hospitals from 1..N.

B. Randomly select eight hospitals.

Method of Selecting Third-stage Sample Items:

A. Number all the credit balances greater between $1,001 and $10,000 belonging to Medicare patients on the most recent inpatient Accounts Receivable Report.

B. Randomly select 100 numbers contained on the list.

C. Evaluate all credit balances greater than $10,000.

Audit Review Time Per Intermediary: 16 weeks

Audit Review Time Per Hospital: 2 weeks

Audit Review Time Per Sample Item: 1 hour

Characteristics To Be Measured:

Error: An error is the amount of a credit balance over 60 days old on the current Accounts Receivable Report and not adjusted by the intermediary.

Treatment of Missing Sample Items:

For missing sample items, an error is included in the sample results. The amount of error to be included is determined by calculating the average error for the sample items which were reviewed.

SUMMARY OF STATISTICAL METHODOLOGY

Estimation Methodology:

A. For our national report, we established the point estimate of the aggregate dollar value of outstanding credit balances between $1,001 and $10,000 plus outstanding credit balances greater than $10,000 in inpatient accounts owed by all the hospitals served by intermediaries nationwide that serve at least 8 hospitals which have a capacity of 200 beds or more.

   Appraisal Method - Multistage Variable Appraisal (Three-stage)

B. For our report on intermediary efficiency, we established the point estimate of the aggregate dollar value of outstanding credit balances between $1,001 and $10,000 plus outstanding credit balances greater than $10,000 in inpatient accounts owed by all the hospitals served by the sampled intermediary.

   Appraisal Method - Multistage Variable Appraisal (Two-stage)

C. For our reports on the individual hospitals, we projected a dollar value and established a reasonable minimum of the dollar value of outstanding credit balances between $1,001 and $10,000 plus outstanding credit balances greater than $10,000 in inpatient accounts over 60 days old, owed to the account of Medicare.

   Appraisal Method - Difference Estimator and Variable Appraisal Method.

Precision and Risk: 90 percent confidence level. We accepted a 5 percent risk that the lower bound of the actual value will be less than the confidence interval.

OUTPATIENT CREDIT BALANCE ACCOUNTS

Audit Objective:

The objective of our audit is to determine if the hospitals and intermediaries reviewed are treating credit balances occurring in outpatient accounts in accordance with Medicare regulations, including the guidelines

SUMMARY OF STATISTICAL METHODOLOGY

prescribed by the Health Care Financing Administration. We limited our review to credit balances over $100.

Primary Sampling Population:

All the intermediaries across the country that serve at least 8 hospitals which have a capacity of 200 beds or more and that handle Medicare claims.

Secondary Sampling Population:

All of an intermediary's TEFRA and PPS hospitals on the intermediary's list of hospitals that were being serviced by the intermediary at the time the list was obtained.

(Note: The hospital must still be providing services in order to be eligible.)

Third-stage Universes of Credit Balances at Individual Hospitals:

A. Credit balances between $101 and $10,000, in the account of a Medicare patient, on the hospital's most recent outpatient Accounts Receivable Report.

B. Credit balances greater than $10,000, in the account of a Medicare patient, on the hospital's most recent outpatient Accounts Receivable Report.

Primary Sampling Unit: One intermediary

Secondary Sampling Unit: One hospital served by the selected intermediary.

Third-stage Sampling Units:

A. A credit balance between $101 and $10,000, in the account of a Medicare patient, on the hospital's most recent outpatient Accounts Receivable Report as of the date the audit begins.

B. A credit balance greater than $10,000, in the account of a Medicare patient, on the hospital's most recent

SUMMARY OF STATISTICAL METHODOLOGY

outpatient Accounts Receivable Report as of the date the audit begins.

Survey and Background Information:

The sample populations are projected for two separate populations. One population is credit balances between $101 and $10,000 and the second population is the credit balances greater than $10,000.

The results of the point estimates are added for reporting purposes. The error for the populations are reported separately.

Sample Design:

A. Multistage Sampling for reporting results at the national level. (Three-stage)

B. Multistage Sampling for reporting results at the intermediary level. (Two-stage)

C. Simple random sampling for reporting the results at the hospital level.

Primary Sample Size: Eight intermediaries

Secondary Sample Size: Eight hospitals

Third-stage Sample Sizes:

A. Credit balances of 100 between $101 and $10,000.

B. All credit balances greater than $10,000.

Source of Random Numbers: Office of Audit Services Statistical Sampling Software.

Method of Selecting Primary Sample Items:

A. List all intermediaries in the sample frame alphabetically. Number the intermediaries from 1..N.

B. Randomly select eight intermediaries.

SUMMARY OF STATISTICAL METHODOLOGY

Method of Selecting Secondary Sample Items:

A. List all hospitals in the sample frame alphabetically. Number the hospitals from 1..N.

B. Randomly select eight hospitals.

Method of Selecting Third-stage Sample Items:

A. Number all the credit balances greater between $101 and $10,000 belonging to Medicare patients on the most recent outpatient Accounts Receivable Report.

B. Randomly select 100 numbers contained on the list.

C. We evaluated all credit balances greater than $10,000.

Review Time Per Intermediary: 16 weeks

Review Time Per Hospital: 2 weeks

Audit Review Time Per Sample Item: 1 hour

Characteristics To Be Measured:

Error: An error is the amount of a credit balance over 60 days old on the current Accounts Receivable Report and not adjusted by the intermediary.

Treatment of Missing Sample Items:

For missing sample items, an error is included in the sample results. The amount of error to be included is determined by calculating the average error for the sample items which were reviewed.

Estimation Methodology:

A. For our national report, we established the point estimate of the aggregate dollar value of outstanding credit balances between $101 and $10,000 plus outstanding credit balances greater than $10,000 in outpatient accounts owed by all the hospitals served by intermediaries nationwide that serve at least 8 hospitals which have a capacity of 200 beds or more.

SUMMARY OF STATISTICAL METHODOLOGY

Appraisal Method - Multistage Variable Appraisal (Three-stage)

B. For our report on intermediary efficiency, we established the point estimate of the aggregate dollar value of outstanding credit balances between $101 and $10,000 plus outstanding credit balances greater than $10,000 in outpatient accounts owed by all the hospitals served by the sampled intermediary.

Appraisal Method - Multistage Variable Appraisal (Two-stage)

C. For our reports on the individual hospitals, we projected a dollar value and established a reasonable minimum of the dollar value of outstanding credit balances between $101 and $10,000 plus outstanding credit balances greater than $10,000 in outpatient accounts over 60 days old, owed to the account of Medicare.

Appraisal Method - Difference Estimator and Variable Appraisal Method.

Precision and Risk: 90 percent confidence level. We accepted a 5 percent risk that the lower bound of the actual value will be less than the confidence interval.

SUMMARY OF STATISTICAL METHODOLOGY

STATISTICAL PROJECTIONS AT THE 90 PERCENT CONFIDENCE LEVEL

	INPATIENT CREDIT BALANCES		OUTPATIENT CREDIT BALANCES		
	< $10,000	> $10,000	< $10,000	> $10,000	TOTAL
Point Estimate	$85,061,440	$76,765,563	$83,711,171	$19,629,697	$265,167,871
Lower Limit	31,366,440	34,197,440	32,532,334	3,372,942[1]	
Upper Limit	138,756,439	119,333,686	134,890,008	46,291,209	
Standard Error	32,641,337	25,877,279	31,111,755	16,207,606	

COMPUTATION OF MEDICARE OVERPAYMENT COMPUTED AT POINT ESTIMATES

Projected Overpayment to 39 Intermediaries Included in the Sample Universe (point estimates)	$265,167,871
Projected Overpayment at the One Intermediary not Included in the Universe (point estimates)	1,249,179
Total Projected Overpayment (total point estimates)	$266,417,050

[1]The lower limit for this strata was a negative number. Therefore, the actual overpayments identified at the eight intermediaries are considered to be the lower limit.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Memorandum

Date JUL 28 1992

From William Toby, Jr.
Acting Administrator

Subject Office of Inspector General (OIG) Draft Management Advisory Report: "Update on Findings Developed in Our National Review of Medicare Accounts Receivable With Credit Balances," A-03-92-00010

To Inspector General
Office of the Secretary

We have reviewed this report which concerns the OIG's continued review of Medicare accounts receivable with credit balances. A credit balance in Medicare accounts receivable occurs when a hospital receives more than the amount charged to a specific Medicare beneficiary. In this situation a refund is due the Medicare program.

OIG found that $200 million in Medicare overpayments remains to be collected by Medicare intermediaries. A large portion of the overpayments, 46.3 percent, resulted from hospitals billing Medicare and a private insurer for the same service, being reimbursed by both, and keeping both payments. The other major source of overpayments was the intermediaries' failure to detect duplicate billings by hospitals.

OIG is recommending that the Health Care Financing Administration (HCFA) continue its plan of recovery by requiring hospitals to report Medicare credit balance accounts to intermediaries on a quarterly basis. OIG is also recommending that HCFA supplement its previous instructions to intermediaries by requiring a timely response to hospitals' attempts to refund Medicare overpayments, and include in their hospital audits a review of Medicare credit balance accounts that have been written off by the hospitals. HCFA concurs with these recommendations. Our additional comments on the recommendations are attached for your consideration.

Thank you for the opportunity to review and comment on this draft management advisory report. Please advise us if you agree with our position on the report's recommendations at your earliest convenience.

Attachment

Comments of the Health Care Financing Administration (HCFA) on the OIG Draft Management Advisory Report: "Update on Findings Developed in Our National Review of Medicare Accounts Receivable With Credit Balances," A-03-92-00010

Recommendation 1

HCFA should continue its plan of recovery by requiring hospitals to report Medicare credit balance accounts to intermediaries on a quarterly basis.

HCFA Response

HCFA concurs with the recommendation. In April 1991, we initiated mandatory Medicare credit balance reporting requirements for hospitals. As of March, over 9,000 providers have reported total Medicare credit balances of $171.6 million. Of this total, $84.1 million was repaid by providers either in the form of checks or adjustment claims.

This effort was temporarily suspended pending approval by the Office of Management and Budget (OMB) as required by the Paperwork Burden Reduction Act of 1980. OMB has now approved the mandatory credit balance reporting requirements, and HCFA has issued instructions to the Medicare intermediaries directing them to reinstate the credit balance reporting requirements for hospitals. The first report for providers will include all Medicare credit balances on providers' books as of June 30, and is due on August 17. There was no loss of program money due to the suspension of the reporting requirements.

Recommendation 2

HCFA should supplement its previous instructions to intermediaries by requiring them to:

a. Respond in a timely manner to all hospitals' attempts to refund Medicare overpayments identified through review of Medicare credit balance accounts.

b. Include in their hospital audits a review of Medicare credit balance accounts that were written off by the hospitals. All identified Medicare overpayments should be returned to the program.

HCFA Response

HCFA concurs with both parts of this recommendation. With regard to attempts by hospitals to refund Medicare overpayments, HCFA issued instructions on April 8, 1991, advising intermediaries and providers that checks would be accepted as repayment of credit balances. Providers were originally not encouraged

to submit checks because HCFA preferred to have an adjustment claim submitted to facilitate the correction of the patient account information. We have issued updated instructions which reemphasize that intermediaries should accept checks, as well as adjustment bills, for repayment of credit balances.

In order to process adjustments in a more timely fashion, HCFA is currently developing specifications for an electronic system to receive and process adjustment claims. This system should significantly reduce the amount of time needed to process adjustments. In addition, HCFA issued instructions on September 26, 1991, which directed intermediaries to reduce pending adjustment claims to no more than a 2-month workload.

With regard to the second part of this recommendation, HCFA has issued instructions to intermediaries that include the requirement that intermediaries review providers' compliance with the credit balance reporting instructions as part of the regularly scheduled cost report field audits. Specifically, intermediaries must determine if providers attempted to identify all Medicare credit balances, if the providers reported them properly, and if the providers refunded credit balances to the Medicare program in a timely manner. These instructions also require the intermediaries to identify written-off credit balances.

Technical Comments

1. We suggest that the following be added to the first bullet point on page 3 of the report:

   "Regulations governing the Medicare Secondary Payer program require a recipient of a third-party payment who has also received a Medicare conditional payment, to refund Medicare's payment within 60 days."

2. We suggest that OIG not use the term "Medicare credit balances," except when referring to overpayments to the Medicare program. OIG's definition of Medicare credit balance appears to be any credit balance appearing in a Medicare beneficiary's account. We believe this is confusing and are requesting that OIG use HCFA's definition of a Medicare credit balance, a credit balance payable to the Medicare program.

3. We would appreciate knowing the name of the hospital referred to on page 5 of the report.

4. In addition, we are requesting that OIG include some discussion of whether writing off a credit balance is illegal, as opposed to a merely "unacceptable policy."