DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date MAY 14 1992

From Richard P. Kusserow
Inspector General

Subject Review of Medicare Credit Balances in Michigan
(A-05-91-00072)

To William Toby
Acting Administrator
Health Care Financing Administration

This is to alert you to the issuance on May 15, 1992, of our final report. A copy is attached.

The report discloses that Medicare accounts receivable credit balances included unidentified overpayments totaling an estimated $8.6 million in the State of Michigan. The estimated overpayments are associated with 56 hospitals in Michigan serviced by Blue Cross and Blue Shield of Michigan (BCBSM) as the Medicare fiscal intermediary (FI). The overpayments existed because both the hospitals and BCBSM did not review credit balances and process adjustments timely. We are recommending recovery of the overpayments and procedural improvements to ensure that the hospitals and BCBSM perform more timely reviews.

The Office of Inspector General conducted a nationwide review of credit balances at 64 hospitals and 8 FIs. This intermediary report is one of the eight FI reports that will be used to estimate the national magnitude of Medicare credit balance overpayments. The objective of our hospital reviews was to determine if hospital credit balances represented Medicare overpayments and whether the hospitals were refunding overpayments to the Medicare program within 60 days. The objective of our review at BCBSM was to evaluate its hospital credit balance monitoring and processing procedures.

We selected 8 of the 56 Michigan hospitals with 200 or more beds as the basis of our statistical sample projection. Our review of credit balances at these hospitals showed that they received overpayments totaling $703,181 which should have been refunded to the Medicare program. Projecting these results to the 56 hospitals, we estimated that these hospitals received $8.6 million in Medicare overpayments and retained the overpayments for more than 60 days. The overpayments remained on the hospitals' records more than 60 days because (i) either the hospitals did not

have adequate procedures to review overpayments or adequate follow-up procedures once overpayments had been identified and (ii) BCBSM and hospitals did not process adjustments timely.

We are recommending that BCBSM:

- eliminate its backlog of unprocessed hospital adjustments,
- establish procedures to ensure that hospital submitted adjustments are processed in a timely manner,
- direct its providers to develop and implement procedures for the proper filing of adjustments,
- improve its Provider Audit Unit coverage, and
- ensure that the hospitals comply with the recommendations we made to each of the eight Michigan hospitals we reviewed.

We issued separate reports to the eight Michigan hospitals we reviewed and we provided a draft copy of this report to BCBSM for review and comment. The BCBSM generally concurred in our findings and recommendations. The BCBSM stated that it has enhanced and/or implemented procedures for detecting and processing hospital adjustments in a timely manner. However, BCBSM indicated that the Health Care Financing Administration requires FIs to process adjustments at the beneficiary level, not at the hospital level. Therefore, BCBSM took exception to our recommendation requesting that they ensure that the eight hospitals we reviewed comply with the recommendations we made individually to each one of them.

For further information, contact:
Martin D. Stanton
Regional Inspector General
for Audit Services, Region V
FTS: 353-2618

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE CREDIT BALANCES IN MICHIGAN

Richard P. Kusserow
INSPECTOR GENERAL

A-05-91-00072

DEPARTMENT OF HEALTH AND HUMAN SERVICES
REGION V
105 W. ADAMS ST.
CHICAGO, ILLINOIS 60603-6201

OFFICE OF
INSPECTOR GENERAL

Common Identification No. A-05-91-00072

Ms. Rosalee Livingston
Vice President, Government Business Group
Blue Cross & Blue Shield of Michigan
600 Lafayette East
Detroit, Michigan 48226-2998

Dear Ms. Livingston:

Enclosed for your information and use are two copies of an Office of Inspector General report titled "Review of Medicare Credit Balances in Michigan". Your attention is invited to the audit findings and recommendations contained in the report. The Health Care Financing Administration action official will contact you to resolve the issues in the report. Any additional comments or information you believe may have a bearing on the resolution of the audit may be presented at that time.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG reports issued to Department's 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 the Department chooses to exercise. (See 45 CFR Part 5).

Please refer to Common Identification Number A-05-91-00072 in all correspondence relating to this report.

Sincerely,

Martin D. Stanton
Regional Inspector General
for Audit Services

Enclosures

SUMMARY

We completed our reviews of Medicare credit balances at eight hospitals in Michigan and the fiscal intermediary (FI) for Michigan, Blue Cross Blue Shield of Michigan (BCBSM). A Medicare credit balance occurs when reimbursements for services provided to a Medicare beneficiary exceed the charges billed according to the provider's accounting records. The objective of our hospital reviews was to determine if hospital credit balances represented Medicare overpayments and whether the hospitals were refunding overpayments to the Medicare program through BCBSM within 60 days. The objective of our review at the FI was to evaluate BCBSM's hospital credit balance monitoring and processing procedures.

We performed our reviews at eight Michigan hospitals and BCBSM. We found that three hospitals did not routinely review their Medicare credit balances to determine whether overpayments existed which should be refunded to the Medicare program. In addition, we found that although five of the hospitals identified and referred Medicare overpayments to the Intermediary, generally BCBSM did not process their requests for adjustment. As a result, overpayments of $703,181 that should have been refunded to Medicare were retained by the eight hospitals. Projecting these results to all 56 of the comparable hospitals serviced by BCBSM, we estimated that the 56 hospitals have received and retained an estimated $8.6 million in Medicare overpayments.

We attributed identified overpayments, at the three hospitals which did not routinely review Medicare credit balances, to the lack of hospital policies and procedures providing guidance for the timely review of credit balances and subsequent reporting of identified overpayments.

We determined that one of the five hospitals, which identified overpayments to the FI, wrote off approximately $2.8 million in Medicare credit balances for the year ended June 30, 1991. This action was taken after BCBSM did not process requests for adjustments of Medicare overpayments within 60 days of notification by the hospital. We included the appropriate corrective recommendation in the hospital's report.

The BCBSM representatives stated that for those hospitals submitting adjustments to the Intermediary, adjustments were not processed due to a number of causes. These causes include:

- the use of three different claims processing systems since calendar year 1987,
- the low priority given to the processing of hospital submitted adjustments in comparison to the higher priority given to the processing of adjustments submitted by the Michigan peer review organization (PRO),
- an employee strike during 1987, and
- the quarterly credit balance reporting requirement initiated by the Health Care Financing Administration (HCFA) but suspended August 12, 1991.

Our review at the FI showed that BCBSM does not have inventory controls in place for the unprocessed adjustments received at BCBSM. Since HCFA has already required intermediaries to implement inventory controls, effective January 1, 1992, we are not making corrective recommendations at this time.

Our review of BCBSM provider audit procedures disclosed that although the audit program directs auditors to obtain the most current credit balance listing from the hospitals during its review, the program requires a review of only those credit balances with dates of services applicable to the cost report year being reviewed. In addition, once the applicable cost report year credit balances were identified, the audit program only required the review of Medicare Secondary Payor (MSP) overpayments and, therefore, did not include steps to identify Medicare overpayments that were due to other causes.

We are recommending that BCBSM:

1. Eliminate its backlog of unprocessed hospital adjustments.
2. Establish procedures to ensure that hospital submitted adjustments are processed in a timely manner.
3. Direct providers that the FI services to develop and implement policies and procedures to identify and review all Medicare credit balances on a timely basis and promptly notify BCBSM when Medicare overpayment refunds are due.

4. Direct the Provider Audit Unit to:

   (a) expand the scope of its audit program to include steps for the detection and review of all types of Medicare overpayments, not only MSP overpayments, and

   (b) refer identified Medicare credit balances not applicable to cost report years being reviewed to responsible BCBSM representatives for appropriate follow up action.

5. Ensure that the eight hospitals we reviewed comply with the recommendations made in each of the individual reports and refund the overpayments cited.

CONTENTS

INTRODUCTION

BACKGROUND

The Social Security 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. Hospitals are reimbursed for inpatient and outpatient services by fiscal intermediaries (FI). These intermediaries are under contract with the Health Care Financing Administration (HCFA) to make Medicare payments. 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 BCBSM.

A credit balance in a Medicare account receivable occurs when a hospital records a higher reimbursement than the amount charged for a specific Medicare beneficiary. 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 Medicare program.

SCOPE

Our reviews at both the hospitals and FI were made in accordance with generally accepted government auditing standards. The objective of the eight hospital reviews was to determine if the Medicare credit balances recorded on hospital records represented Medicare overpayments and if hospitals were refunding the overpayments to the Medicare program through BCBSM within 60 days. The objective of our review at the FI was to evaluate BCBSM's hospital credit balance monitoring and processing procedures.

Our reviews are part of a nationwide review on Medicare credit balances being performed by the Region III Office of Audit

Services. Region III randomly selected eight FIs nationwide and eight hospitals served by each FI. In Region V, BCBSM was one of two FIs selected.

We did not perform a detailed review of the eight hospitals' internal controls but did perform a limited review of internal controls at BCBSM. Our audit included extensive substantive testing thereby reducing our need to perform thorough internal control reviews. We limited our review of internal controls at the hospitals to determining (1) whether we could rely on the contents of credit balance listings provided for audit purposes and (2) whether the hospitals had policies and procedures for reporting overpayments to the FI. We limited our review of internal controls at BCBSM to determining whether controls existed over adjustment requests submitted by hospitals to correct overpayments.

To estimate the overpayments due to the Medicare program, we used a multistage sample to project our results at the eight hospitals reviewed. The primary sampling unit was a hospital and the secondary sampling unit was a credit balance.

Our review was limited to Medicare outpatient and inpatient credit balances on the eight hospitals' records at the time of our review. We considered inpatient and outpatient credit balances separate universes. We also limited our review to outpatient credit balances over $100 and inpatient credit balances over $1,000. If a hospital had less than 100 credit balances in a universe, we included all the credit balances in our review. For hospitals with over 100 credit balances in a universe, we randomly selected 100 of the credit balances for review. All credit balances over $10,000 were reviewed.

Our review was also limited to hospitals with 200 beds or more. There were 56 such hospitals in Michigan. We projected the results of our eight hospital reviews to the universe of 56 hospitals using the difference estimator. The OIG Office of Audit Services multistage software programs were used to make the projections. Our projections and recommended adjustments were limited to overpayments over 60 days old.

We analyzed Medicare credit balances at the eight hospitals to determine if overpayments had occurred. We reviewed such records as credit balance listings, Medicare remittance advices, patient accounts receivable detail, patient bills and patient registration forms.

We followed up our hospital reviews with a review at BCBSM. We selected a judgmental sample of unprocessed adjustments, noted during our hospital reviews, to determine their status at BCBSM. We reviewed a judgmental sample of duplicate payments to

determine why they were not detected by BCBSM. We also reviewed BCBSM's provider audit procedures to determine the extent that BCBSM reviews hospital credit balances.

Other than the issues discussed in the **FINDINGS AND RECOMMENDATIONS** section of this report, we found no instances of noncompliance with applicable laws and regulations. With respect to those items not tested, nothing came to our attention to cause us to believe that untested items were not in compliance with applicable laws and regulations.

Our field work was performed at the eight hospitals and at BCBSM's offices in Michigan during the period June 1991 to November 1991.

FINDINGS AND RECOMMENDATIONS

ESTIMATED OVERPAYMENTS

Our review of eight Medicare participating hospitals serviced by BCBSM showed that all of the hospitals had Medicare credit balances recorded on their accounting records at the time of our review. We found that we could rely on the contents of credit balance listings developed from the accounting records for seven of the eight hospitals. We noted that one hospital had written off approximately $2.8 million in Medicare credit balances from its accounts receivables for the year ended June 30, 1991. Accordingly, we could not rely on this hospital's listing of credit balances provided for our review. Additional details concerning this matter are provided in the **OTHER HOSPITAL PRACTICES** section of the report.

We reviewed 1,185 Medicare outpatient and inpatient credit balances at the hospitals and found that 432 (36%) represented Medicare overpayments totaling $703,181 ($243,029 for outpatient services and $460,152 for inpatient services). See Appendix A and Appendix B for individual hospital results.

Projecting the results of our hospital reviews to the universe of 56 Michigan hospitals with 200 or more beds, we estimate that these Michigan hospitals owe HCFA $8,594,621 in credit balances over 60 days old. The $8,594,621 represents the point estimate of our sample projections. The point estimate for the inpatient projection was $3,298,745 with a standard error of $1,031,653. The point estimate for the outpatient projection was $5,295,876 with a standard error of $1,536,435.

None of the $703,181 had been recouped by BCBSM prior to our hospital reviews. However, during our field work, $9,429 was refunded by the hospitals and additional refunds were made after our hospital field work was completed. With respect to refunds that were made during and after our hospital audits, we recommended that HCFA take refunded overpayments into consideration during the final resolution process.

The identified overpayments remained on hospital records for periods in excess of 60 days. We noted that hospitals retained 71 percent of the reviewed overpayments for over 200 days after the date that they occurred. We concluded that Medicare overpayments remained on the hospitals' records for long periods for two major reasons.

(1) Although five of the eight hospitals identified and referred overpayments to the FI in a timely manner, either

the FI (a) did not make the adjustments necessary to recover the overpayments or (b) generally did not recover overpayments within 60 days of the hospitals' identification of the overpayments.

(2) Three hospitals, generally, did not routinely review their Medicare credit balances to identify overpayments to the FI.

Intermediary Adjustment Processing

Our reviews disclosed that five of the eight hospitals reviewed their credit balance listings to identify Medicare overpayments and submitted adjustments to BCBSM for overpayment processing. However, BCBSM generally did not process the adjustments. Our review at BCBSM disclosed that the average inventories of pending adjustments for calendar years 1987 through 1990 were as follows:

Year	Adjustments Pending At Year End	Adjustments Pending Monthly Average
1987	22,521	26,044
1988	18,828	20,456
1989	13,086	14,871
1990	22,054	13,456

At the end of June 1991, there were 24,418 unprocessed adjustments and the monthly average of pending adjustments for the first six months of 1991 was 25,921. Although these totals include adjustments identified by the Michigan PRO prior to 1990, the majority of the adjustments represented hospital submitted adjustments. For example, as of January 1990, 69 percent of the adjustments on hand were submitted by hospitals. During 1990, the Michigan PRO begin to submit about 1500 adjustments per month and, as a result, hospital submitted pending adjustments declined to about 45 percent of the inventory by December 1990. As of October 25, 1991, there were 20,326 pending adjustments, of which 11,689 or 57 percent were submitted by hospitals.

The BCBSM representatives informed us that the backlog of pending adjustments existed due to:

(1) The use of three different claims processing systems since calendar year 1987;

(2) The low priority given to processing of adjustments submitted by providers;

(3) An employee strike during calendar year 1987; and

(4) The HCFA quarterly credit balance reporting initiative.

Prior to February 1987, BCBSM used the Model A claims processing system, which included a number of automated adjustment processing steps. On February 17, 1987, the California Standard System was implemented. However, the automated adjustment processing portion of the system was not operational until May 1988. In order for an adjustment to be processed during the interim period, it had to be manually keyed into the data system twice; once to back out the incorrect payment and once to enter the correct payment.

The current system, the Advance Claims Processing System, was implemented on July 2, 1990. This system does not include any automated adjustment processing steps and also requires the previously described manual entries of data into the system.

During July 1990, the PRO began to submit adjustments at the rate of about 1,500 per month. The BCBSM gave priority to the PRO adjustments and, therefore, did not process provider submitted adjustments until January 1991.

The BCBSM representatives said that employees went on strike from September 1, 1987 through November 22, 1987. Hospital submitted adjustments were not processed during the strike period since HCFA evaluated BCBSM, as part of HCFA's annual Contractor Performance Evaluation Program (CPEP) review, only on the processing of adjustments submitted by the PRO. The BCBSM did not resume its processing of provider submitted adjustments until January 1988.

As a result of the June 1991 instruction requiring hospitals to submit detailed listings of their Medicare credit balances on a quarterly basis, BCBSM received 141 credit balance reports before the requirement was suspended August 12, 1991. These reports listed a total of 5,325 adjustments thereby adding to the backlog of unprocessed adjustments which already existed at BCBSM. A BCBSM representative stated that total pending adjustments were being reduced at the rate of approximately 900 per month. We noted that the inventory of unprocessed provider adjustments was reduced from 12,443 to 11,689, a difference of 754, for the four week period ending October 25, 1991.

During our review, we noted that BCBSM did not maintain adequate controls over unprocessed adjustments submitted by providers. The adjustments were not individually tracked as they were not

keyed into the system or recorded individually when received. Only total counts of adjustments received, processed and on hand were recorded. The hard copy documents, supporting the adjustments, were simply filed in alphabetical order by beneficiary until processing was initiated. The time interval between receipt of the adjustment and initiating the processing of the adjustment was, at times, significant. During this interval, there was no means of identifying the status of individual adjustments at the Intermediary.

The HCFA is aware of the lack of controls over adjustments and, in a letter dated September 26, 1991, directed intermediaries to implement controls for all provider adjustments received January 1, 1992, or later. Therefore, we are not making corrective recommendations for the lack of controls noted.

Hospital Review of Credit Balances

We noted that three of the eight hospitals generally did not review their credit balances to identify Medicare overpayments. Except for one credit balance account, at two of the hospitals there was no documentation available to support reviews of credit balances. In fact, one hospital, when notified of our audit, indicated that it had no reasonable method to ascertain the credit balances that should be reviewed. Although we did note that the third hospital requested adjustments for 22 of 67 Medicare overpayments identified, we considered the hospital's review efforts to be inconsistent. We concluded that the hospital did not adequately review Medicare credit balances since adjustment requests were not submitted to the FI for two thirds of the identified overpayments.

We estimated that these three hospitals received and retained Medicare overpayments of approximately $644,000 (including sample projections). We attributed these overpayments to a lack of formal written policies and procedures for the timely review of Medicare credit balances and subsequent reporting of identified overpayments to BCBSM.

OVERPAYMENT CATEGORIES

Our hospital reviews identified three primary Medicare overpayment categories, which are summarized below.

Services Reimbursed by Another Insurer

We found that Medicare overpayments totaling $293,414 resulted from hospitals billing Medicare and a commercial insurer for the

same service and receiving primary payments from both. When the hospitals received payments from both insurers, the hospitals established credit balances for the excess reimbursements. However, in some instances, the hospitals did not routinely resolve the credit balances. For these cases we found that the other insurer was primary payor and, therefore, the Medicare payments represented overpayments to the hospitals.

Duplicate Billing of Services

We estimated that Medicare overpayments totaling $182,550 resulted from hospitals submitting duplicate claims that went undetected by BCBSM. We attributed 114 of the 432 overpayments found at the hospitals to duplicate billings.

During our review at BCBSM, we selected a judgmental sample of 28 duplicate payments. We wanted to determine why BCBSM did not detect the duplicate claims that were submitted by the hospitals. We were able to determine a cause for only five of the 28 duplicate payments. Our analysis of these five is as follows:

- One claim was identified as a potential duplicate payment by the system edits but it was manually overridden and paid by BCBSM personnel.

- Three duplicate payments occurred because hospitals submitted duplicate claims using different dates of service for the same service or added additional charges with different revenue codes to previously submitted claims .

- One duplicate payment occurred because the BCBSM system edits, in some cases, did not detect duplicate claims processed on the same day as original claims. Intermediary representatives informed us that this system problem has been corrected.

Since BCBSM's data files did not provide sufficient information for us to determine why 23 of the 28 duplicate payments occurred, we were not able to determine the primary reasons for the duplicate payments and, therefore, are not making corrective recommendations.

Services Not Performed

We estimated that Medicare overpayments totaling $181,657 resulted from hospitals billing for services not performed. We found that some of the hospitals, subsequent to submitting claims to BCBSM, became aware that not all services billed to

beneficiaries were performed. These hospitals cancelled the charges on their records but did not inform BCBSM of the cancellations. Since the FI processed the billings, Medicare reimbursements exceeded the hospitals' adjusted charges and thereby established Medicare credit balances for the overpayments.

INTERMEDIARY AUDITS OF CREDIT BALANCES

The BCBSM's Provider Audit Unit reviewed hospital Medicare credit balance accounts through its audits of hospital cost reports. We found that recent BCBSM audit activity generally did not cover hospital credit balances within our scope of audit. The Provider Audit Unit's 1990 and 1991 fiscal years activity included the following number of field audits of credit balances for the hospitals included in our sample:

Cost Report Year	Number of Field Audits
1987	4
1988	4
1989	1

The cost report year for the hospital audited for 1989 ended June 30, 1989. The credit balance listings we used for our reviews, dated April/May 1991, generally were comprised of credit balances identified after June 1989. Consequently, most of the credit balances we reviewed occurred subsequent to BCBSM audits.

We found that although the Provider Audit Unit audit program directed auditors to obtain the most current credit balance listing from the hospitals served by BCBSM, the program required a review of only those credit balances with dates of services applicable to the cost report year being reviewed. This procedure allowed the hospital to retain potential Medicare overpayments for excessively long periods. The Provider Audit Unit should refer Medicare credit balances not reviewed to responsible BCBSM representatives for appropriate follow up action.

We also noted that the credit balance audit program used by BCBSM concentrated entirely on identifying MSP overpayments. Medicare overpayments applicable to other causes, such as duplicate payments, billings for services not provided and outpatients admitted as inpatients were ignored. Since only 42 percent of

the overpayments identified during our review pertained to MSP findings, we conclude that significant Medicare overpayments are not being identified due to the limited scope of the Provider Audit Unit audit program.

OTHER HOSPITAL PRACTICES

We found one hospital that adjusted Medicare credit balances to zero by charging the credit balances to a miscellaneous income account. The hospital wrote off credit balances when BCBSM did not process adjustment requests within 60 days of notification by the hospital.

After these credit balances have been eliminated, the audit trail for Medicare overpayments is difficult to follow. There was no indication on the hospital's accounts receivable records that Medicare overpayments existed. A hospital representative said that for the year ended June 30, 1991, the hospital wrote off 233 Medicare credit balance accounts that amounted to approximately $2.8 million. However, BCBSM representatives said they were not aware of the hospital's practice of charging credit balance amounts to a miscellaneous income account.

CONCLUSIONS AND RECOMMENDATIONS

We found Medicare overpayments in the amount of $703,181 at the eight hospitals we reviewed that should have been refunded to the Medicare program prior to our review. Projecting our results to the universe of 56 Michigan hospitals with 200 or more beds, we estimate that hospitals have retained as much as $8.6 million of Medicare overpayments in beneficiary accounts with credit balances.

We found that BCBSM and the hospitals shared responsibility for the Medicare overpayments identified and not repaid to the Medicare program. The BCBSM did not process adjustments submitted by hospitals to correct the overpayments and the hospitals did not always review their credit balances to determine if overpayments were made and, if so, promptly submit adjustments to the FI.

We believe procedural improvements are needed at the hospitals and at BCBSM if Medicare overpayments are to be identified and refunded timely. We previously made recommendations to the hospitals. We further recommend that BCBSM:

1. Eliminate its backlog of unprocessed hospital submitted adjustments;

2. Establish procedures to ensure that future hospital submitted adjustments are processed in a timely manner;

3. Direct all providers that the FI services to develop and implement policies and procedures to identify and review all Medicare credit balances on a timely basis and promptly notify BCBSM when Medicare overpayment refunds are due;

4. Direct the Provider Audit Unit to:

   (a) expand the scope of its MSP audit program to include steps for the detection and review of all types of Medicare overpayments, not only MSP overpayments, and

   (b) refer identified Medicare credit balances not applicable to cost report years being reviewed to responsible BCBSM representatives for appropriate follow up action; and

5. Ensure that the eight hospitals we reviewed comply with the recommendations made in each of the individual reports and refund the overpayments cited.

BCBSM COMMENTS

BCBSM concurred with four of our five recommendations. The FI took exception to our recommendation that BCBSM ensure the eight hospitals we reviewed comply with the recommendations made in each of the individual reports and refund the overpayments cited (recommendation #5). In response to this recommendation, BCBSM stated that adjustments are made at the beneficiary level as directed by HCFA. The FI contended that the adjustment process is broader in scope than a "separate hospital specific approach" and that the present process avoids double recoveries. The FI added that BCBSM personnel are required to maintain accurate beneficiary records and that the accuracy of the records can only be accomplished by making adjustments to the individual beneficiary records. Accordingly, the BCBSM administration believes that by becoming current in their adjustment processing they have complied with our recommendation #5 discussed above.

OIG RESPONSE

We agree with BCBSM's comments that adjustments at the beneficiary level are necessary to maintain accurate beneficiary records. However, this process does not ensure that hospitals are submitting adjustments to the FI. We found that three of the

eight hospitals we reviewed did not routinely review their credit balance accounts and identify Medicare overpayments to BCBSM. In addition, two of the five hospitals that did review credit balances reduced the priority with respect to submitting adjustments since BCBSM was not processing the adjustment requests in a timely manner. BCBSM's system of processing adjustments at the beneficiary level does not permit BCBSM to identify these and other hospitals that are negligent in reporting Medicare credit balances and which may be retaining significant Medicare overpayments. Therefore, we continue to recommend that BCBSM ensure that the eight hospitals we reviewed comply with the recommendations made in each of the individual reports and refund the overpayments cited.

Martin D. Stanton
Regional Inspector General
for Audit Services

APPENDICES

APPENDIX A

INPATIENT CREDIT BALANCES
RESULTS OF HOSPITAL REVIEWS

HOSPITAL	NUMBER OF CREDIT BALANCES REVIEWED	OVERPAYMENTS NUMBER	OVERPAYMENTS AMOUNT
CRITTENTON HOSPITAL	53	11	$ 28,081
PROVIDENCE HOSPITAL	53	19	181,974
HENRY FORD HOSPITAL	117	9	46,489
ST JOSEPH HOSPITAL	49	12	49,014
SPARROW HOSPITAL	50	24	92,151
MARQUETTE GENERAL HOSPITAL	27	10	35,098
INGHAM MEDICAL CENTER	7	3	3,342
HUTZEL HOSPITAL	93	4	24,003
TOTALS	449	92	$460,152

APPENDIX B

OUTPATIENT CREDIT BALANCES
RESULTS OF HOSPITAL REVIEWS

HOSPITAL	NUMBER OF CREDIT BALANCES REVIEWED	OVERPAYMENTS NUMBER	OVERPAYMENTS AMOUNT
CRITTENTON HOSPITAL	100	42	$ 11,558
PROVIDENCE HOSPITAL	103	52	30,716
HENRY FORD HOSPITAL	104	23	41,042
ST JOSEPH HOSPITAL	101	55	25,459
SPARROW HOSPITAL	101	59	49,158
MARQUETTE GENERAL HOSPITAL	90	37	31,928
INGHAM MEDICAL CENTER	36	25	11,728
HUTZEL HOSPITAL	101	47	41,440
TOTALS	736	340	$243,029

Appendix C

Medicare

Blue Cross
Blue Shield
of Michigan

Rosalee Livingston
Vice President
Government Business Group

600 Lafayette East
Detroit, Michigan 48226

February 26, 1992

Mr. Martin D. Stanton
Regional Inspector General
for Audit Services
Region V
105 West Adams St.
Chicago, IL 60603-6201

Re: Common Identification No. A-05-91-00072

Dear Mr. Stanton:

We have reviewed the draft report on the reviews of Medicare credit balances at eight (8) hospitals in Michigan. Stated below are our reply comments.

Recommendations:

1. "Eliminate its backlog of unprocessed hospital adjustments."

   In July, 1991, Blue Cross and Blue Shield of Michigan (BCBSM) submitted to the Health Care Financing Administration (HCFA) an action plan addressing the elimination of the backlog of pending adjustments. As noted in the report, HCFA mandated that Fiscal Intermediaries reduce their backlog of adjustments to 60 days work-on-hand by March 1, 1992. We have made this our top priority and it is our intention to have 60 days or less work-on-hand by the March 1, 1992 date.

2. "Establish procedures to ensure that hospital submitted adjustments are processed in a timely manner."

   We have established procedures to control adjustments from receipt to completion. We have established internal standards to process adjustments within 60 days of receipt, and to ensure that the number of pending aged adjustments are minimal. Enhancements to our claims processing system have been requested to aid in processing and control so we can ensure adjustments are processed timely.

3. "Direct providers that the FI services to develop and implement policies and procedures to identify and review all Medicare credit balances on a timely basis and promptly notify BCBSM when Medicare overpayment refunds are due."

   We will republish our Medicare Intermediary Part A Newsletter article to the provider community that directs them to submit timely adjustment reports, which includes credit balances, to us in a manner that is acceptable for adjustment processing. We have previously requested and continue to request providers to submit credit balances on an ongoing basis.

4. "Direct the Provider Audit Unit to:

   (a) expand the scope of its audit program to include steps for the detection and review of all types of Medicare overpayments."

   The Provider Audit unit will expand its audit program to include steps for the detection and review of all types of Medicare overpayments. It should be pointed out here that it was Provider Audit's intention to review all Medicare overpayments and recoup all monies due to the Medicare program prior to the release of the OIG audit.

   (b) "refer identified Medicare credit balances not applicable to cost report years being reviewed to responsible BCBSM representatives for appropriate follow up action."

   This procedure is in place for MSP and non-MSP credit balances.

5. "Ensure that the eight (8) hospitals we reviewed comply with the recommendations made in each of the individual reports and refund the overpayments cited."

   Our current initiative is to reduce our inventory of adjustments to less than a 60 day level by March 1, 1992. Adjustments are at the beneficiary level. Consequently our process is broader in scope and not limited to the 8 hospitals reviewed. We will proceed,

at HCFA's direction, to utilize this process for recoveries rather than a separate hospital specific approach to avoid a double recovery.

We would like to take this opportunity to point out that we are required to maintain accurate beneficiary records and this can only be accomplished by making adjustments to the individual beneficiary's records. Therefore, we maintain our adjustment files by beneficiary and not by provider.

We have complied with the OIG recommendation by becoming current in our adjustment processing.

We are currently in the process of automating our inventory control and PRO adjustment processing. These steps will aid in improving processing timeliness of future adjustments.

In reference to the comment on page 10, second paragraph "... we conclude that significant Medicare overpayments are not being identified due to the limited scope of the Provider Audit unit audit program." Hospitals are not required to maintain credit balance reports or audit trails that are conducive to an audit. We also believe that with the MPRO, MSP and new procedures in processing adjustments that any remaining credit balances for the Provider Audit unit to review would be minimal.

In closing, we believe that we have complied with all requirements requested of us and have recouped all amounts submitted to us on adjustment reports by individual beneficiary.

Sincerely,

Rosalee Livingston

Rosalee Livingston

RL/rja

cc: Judith D. Stec
Warren White
Barbara Hoff