Memorandum

Date MAY 6 1992

From Richard P. Kusserow
Inspector General

Subject Review of Medicare Credit Balances in Wisconsin
(A-05-91-00128)

To William Toby
Acting Administrator
Health Care Financing Administration

This is to alert you to the issuance on May 7, 1992, of our final report. A copy is attached.

The report discloses that Medicare accounts receivable credit balances included unidentified overpayments totaling an estimated $919,826 in the State of Wisconsin. The estimated overpayments are associated with 34 hospitals in Wisconsin serviced by Blue Cross and Blue Shield United of Wisconsin (BCBSUW) as the Medicare fiscal intermediary (FI). The overpayments existed because both the hospitals and BCBSUW did not adequately review credit balances and process adjustments timely. We are recommending recovery of the overpayments and procedural improvements to ensure that the hospitals and BCBSUW perform more adequate and 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 BCBSUW was to evaluate its procedures for monitoring hospital credit balances and processing related adjustments.

We selected 8 of the 34 Wisconsin 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 $197,577 which should have been refunded to the Medicare program. Projecting these results to the 34 hospitals, we estimated that these hospitals received $919,826 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) the hospitals did not have adequate procedures to review overpayments or adequate follow-up procedures once overpayments had been identified and (ii) BCBSUW did not adequately review credit balances through its Provider Audit Unit (PAU) and did not process adjustments timely.

We are recommending that BCBSUW:

- direct its providers to develop and implement procedures to identify and review credit balances, to notify BCBSUW within 60 days when Medicare adjustments are due, and to follow-up when adjustments are not processed in a timely manner;

- direct its PAU to expand its audit programs to include steps for the detection of Medicare overpayments and to define the credit balance information needed from providers to ensure proper recovery of Medicare overpayments;

- eliminate the remaining backlog of unprocessed hospital adjustments and ensure that future adjustments are processed in a timely manner; and

- ensure that the eight Wisconsin hospitals comply with the recommendations we made to each one, respectively.

We issued separate reports to the eight Wisconsin hospitals reviewed and we provided a draft copy of this report to BCBSUW for review and comment. The BCBSUW generally concurred in our findings and recommendations and has initiated corrective action regarding three of our four recommendations. However, BCBSUW officials believe that provider audits are not an effective method of monitoring whether the providers' properly detect and recover Medicare overpayments because of the limited number of provider audits performed per year. Therefore, BCBSUW officials took exception to our recommendation regarding its PAU.

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 WISCONSIN

Richard P. Kusserow
INSPECTOR GENERAL

A-05-92-00128

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

OFFICE OF
INSPECTOR GENERAL

Common Identification No. A-05-91-00128

Mr. Timothy Cullen, President
Government Programs Division
Blue Cross & Blue Shield United of Wisconsin
1515 N. River Center Drive
Milwaukee, Wisconsin 53212

Dear Mr. Cullen:

Enclosed for your information and use are two copies of an Office of Inspector General final report titled, "Review of Medicare Credit Balances in Wisconsin." Your attention is invited to the audit findings and recommendations contained in the report.

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

In accordance with the Principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General reports issued to the 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).

To facilitate identification, please refer to Common Identification Number A-05-91-00128 in all correspondence relating to this report.

Sincerely,

Martin D. Stanton
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:
Judith D. Stec, Associate Regional Administrator
Division of Medicare
Health Care Financing Administration, HHS
105 W. Adams Street, 15th Floor
Chicago, Illinois 60603

SUMMARY

We have completed our review of Medicare credit balances at eight hospitals in Wisconsin. 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. Our primary objective was to determine if hospitals were reviewing credit balances and refunding overpayments to the Medicare program through Blue Cross & Blue Shield United of Wisconsin (BCBSUW), the Intermediary, within 60 days as prescribed by Medicare regulations. In addition, we also determined whether BCBSUW was evaluating hospital compliance with these requirements and processing Medicare adjustments in a timely manner.

Our review showed that the eight hospitals had identified 92 percent of the overpayments and requested adjustments from BCBSUW, however, BCBSUW did not process the hospitals' requests for adjustment in a timely manner. We also found that the hospitals took no action on the remaining 8 percent of the credit balances we identified as overpayments. As a result, the eight hospitals retained overpayments of $197,577 that should have been refunded to Medicare. Projecting these results to the 34 comparable hospitals serviced by BCBSUW, we estimate these 34 hospitals retained $919,826 in Medicare overpayments.

We determined that the eight hospitals retained the $197,577 and took no action on 8 percent of the credit balances we identified as overpayments for the following reasons: (1) a lack of written policies and procedures for the timely review of credit balances, reporting of overpayments and subsequent follow-up on unprocessed adjustments, (2) an unawareness of the requirement to refund Medicare overpayments within 60 days, and (3) no procedures to follow-up on adjustments that were not processed within a reasonable period of time.

While the hospitals were primarily responsible for refunding the Medicare overpayments, BCBSUW was responsible for ensuring that hospitals complied with Medicare regulations and for processing adjustments in a timely manner. We found that the reviews performed by BCBSUW's Provider Audit Unit did not adequately monitor credit balances because the auditors: (1) examined only a small number of hospitals each year, (2) reviewed primarily Medicare Secondary Payor (MSP) related information, (3) did little or no verification of the credit balance information, and (4) obtained credit balance listings which did not contain sufficient information to process recovery adjustments.

We also noted that, until recently, BCBSUW had a significant number of adjustments pending because they gave higher priority to processing current claims than processing adjustments. In addition, BCBSUW did not have an inventory control system to account for non-

MSP adjustments. Since the Health Care Financing Administration (HCFA) has recently required that all intermediaries implement inventory controls over adjustments, effective January 1, 1992, we are not making corrective recommendations on this finding.

In conclusion, procedural improvements are needed at the hospitals and at BCBSUW to ensure that Medicare overpayments are identified and refunded in a timely manner. We are recommending that BCBSUW:

1) Direct providers to:

   (a) implement procedures to identify and review Medicare credit balances,

   (b) notify BCBSUW within 60 days when Medicare adjustments are due, and

   (c) follow-up with BCBSUW when adjustments are not processed in a timely manner.

2) Direct Provider Audit to:

   (a) expand the scope of its audit program to include steps for the detection of Medicare overpayments other than just MSP overpayments, and

   (b) define the credit balance information needed from providers to ensure that sufficient detail is present to take recovery action.

3) Eliminate the remaining backlog of unprocessed hospital adjustments and ensure that future adjustments are processed in a timely manner.

4) Ensure that the eight hospitals identified in this report comply with the procedural recommendations made in each individual audit report and refund the $197,577 in Medicare overpayments that were identified.

BCBSUW officials generally concurred with our recommendations and have initiated corrective action regarding three of our four recommendations. However, BCBSUW officials believe that provider audits are not an effective method of monitoring whether the providers' properly detect and recover Medicare overpayments because of the limited number of provider audits performed per year. BCBSUW's written comments are summarized after the Conclusions and Recommendations section of this report and included in their entirety as Appendix C.

TABLE OF 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 intermediaries. These intermediaries are under contract with the Health Care Financing Administration (HCFA) to make Medicare payments. Intermediaries are required to audit hospital costs to ensure that the costs adhere to Federal regulations and HCFA guidelines. The intermediary for the hospitals in our review is Blue Cross & Blue Shield United of Wisconsin (BCBSUW).

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 payments made by an intermediary and other insurers for the same service provided to the same patient, from payment made for an anticipated service that was not actually provided and from duplicate payments made by an intermediary. In these cases, a Medicare overpayment exists and should be refunded to the intermediary.

In cases where an overpayment exists, Medicare regulation 42 CFR Part 489.20(h) requires that a provider return the overpayment to the Medicare program within 60 days.

SCOPE

Our audit was made in accordance with generally accepted government auditing standards. The primary objective of our audit was to determine if hospitals were reviewing credit balance accounts to identify Medicare overpayments and refunding the overpayments to the Medicare program through BCBSUW within 60 days. As a secondary objective, we determined if BCBSUW was, during its provider audits, evaluating hospital procedures for reviewing and refunding Medicare credit balance accounts and also whether BCBSUW was processing adjustments in a timely manner.

Our review was part of a nationwide audit of Medicare credit balances being performed by the Region III Office of Audit Services. Region III randomly selected eight intermediaries nationwide and eight hospitals served by each intermediary (64 hospitals nationwide). In Region V, BCBSUW was one of two intermediaries selected. The random selection of the eight sample hospitals, serviced by BCBSUW, was limited to those hospitals with 200 or more beds. There were 34 such hospitals in Wisconsin.

A detailed review of internal controls was not performed at either the eight sample hospitals or BCBSUW because substantive testing reduced 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 Intermediary. Our review of internal controls at BCBSUW was limited to (1) reviewing the Provider Audit examinations of credit balances and (2) determining whether controls existed over the adjustment requests submitted by hospitals to correct Medicare overpayments.

Our audit was limited to Medicare inpatient and outpatient credit balances recorded on the eight hospitals' accounting records at the time they were notified of our review. Inpatient and outpatient credit balances were considered separate universes. We also limited our review to inpatient credit balances over $1,000 and outpatient credit balances over $100. If a hospital had less than 100 credit balances in a universe, we examined all of the credit balances. Further, all credit balances over $10,000 were examined. To determine if Medicare credit balances represented overpayments, we analyzed appropriate hospital records such as Medicare remittance advices, patient accounts receivable detail, hospital bills, patient registration forms and Medicare adjustment forms.

Two hospitals in our sample each had significantly more than 100 outpatient credit balances. We established each hospitals' universe of outpatient credit balances exceeding $100 and randomly selected 100 credit balances from each universe for review. We projected the results of our statistical sample to each hospital's universe using the standard Office of Audit Services software program for variable samples.

The inpatient and outpatient results from our eight hospital reviews were then projected to the universe of 34 Wisconsin hospitals using the Office of Audit Services three-stage variable software program. Our projection and recommended adjustments were limited to overpayments that were more than 60 days old at the time of fieldwork and not recovered by BCBSUW.

Our hospital audits were followed with a review at BCBSUW. We examined BCBSUW's Provider Audit procedures to determine the extent and adequacy of their reviews of hospital credit balances. In addition, we examined the system for controlling and processing adjustment forms submitted by the providers.

Other than the issues discussed in the **FINDINGS** and **CONCLUSIONS AND RECOMMENDATIONS** sections 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 the untested items were not in compliance with applicable laws and regulations.

Our fieldwork was performed at the eight hospitals during the months of June through August 1991 and at BCBSUW in October 1991.

FINDINGS

ESTIMATED OVERPAYMENTS

Our audit of eight selected hospitals showed that all of the hospitals had Medicare credit balances recorded on their accounting records at the time of our review. We found that the credit balances at seven of the eight hospitals represented $197,577 of unrecovered Medicare overpayments that were more than 60 days old. Further, based on our reviews at the sample hospitals, we estimate that $919,826 of unrecovered Medicare overpayments over 60 days old exist at the 34 Wisconsin hospitals with 200 beds or more.

We reviewed a total of 549 inpatient and outpatient credit balances, at the eight sample hospitals, and identified 284 Medicare overpayments amounting to $353,659. The hospitals identified the majority of the overpayments and submitted at least one adjustment form to BCBSUW for recovery of the overpayments. By the time of our audit field work, BCBSUW had recovered $156,082 in provider submitted adjustments for 149 overpayments. The remaining 135 Medicare overpayments, totaling $197,577, were more than 60 days old and had not been refunded to BCBSUW. These unrecovered overpayments were comprised of $163,323 related to inpatient accounts and $34,254 related to outpatient accounts. (See Appendices A and B for individual hospital results).

Projecting the $197,577 in overpayments from our hospital reviews to the universe of 34 Wisconsin hospitals with 200 beds or more, we estimate that $919,826 in unrecovered overpayments, more than 60 days old, are owed to the Medicare program. The $919,826 represents the combined point estimates from our inpatient and outpatient sample projections. The point estimate for the inpatient projection was $694,123 and the precision at the 90 percent confidence level was +/- $353,996. The point estimate for the outpatient projection was $225,703 with a precision of +/- $165,805 at the 90 percent confidence level.

These overpayments remained on hospital accounting records for periods in excess of the 60 days allowed in the Federal regulations. For the eight hospitals reviewed, inpatient credit balances were retained an average of 399 days and outpatient credit balances were retained an average of 424 days at the time of our field work. (See Appendices A and B for individual hospital averages.)

Our determinations of Medicare overpayments were based on credit balance listings developed for us from the accounting records of the eight hospitals. Our analysis of these listings disclosed that the data included on the respective listings was reliable.

OVERPAYMENT CATEGORIES

Based on our review, we identified three primary types of Medicare overpayments as follows: (1) services reimbursed by both Medicare and another insurer, (2) duplicate claims that were undetected by BCBSUW and (3) miscellaneous reasons.

Services Reimbursed by Another Insurer. Medicare overpayments of $142,648, or 72 percent of the $197,577 total overpayments, resulted from hospitals billing both Medicare and a commercial insurer for the same service and receiving primary payment from both payers. The provisions of the MSP program state that Medicare will not pay for services which are reimbursable by another insurer. In general, we found that the hospitals billed Medicare as the primary payor, based on admissions information, and subsequently learned that the patient had other primary insurance coverage.

Duplicate Claims. Our audits disclosed that 13 percent of the Medicare overpayments, or $26,767, resulted from hospitals submitting duplicate claims that went undetected by BCBSUW. Most of the undetected duplicate claims represent a situation in which the services that a hospital rendered to a beneficiary were billed to Medicare twice using different procedure codes or dates of service. Some undetected duplicates were attributable to hospitals submitting both inpatient and outpatient claims for the same service.

We found that BCBSUW claim reviewers selectively determine which computer edits the Medicare claims will be processed against. Our review of several claims, judgementally selected from our hospital audits, demonstrated that this system of selective edits did not identify all duplicate charges.

Miscellaneous. Eight percent of the $197,577 in Medicare overpayments, or $14,803, resulted from two accounts at Meriter Hospital. For one account, unallowable pharmacy charges were billed and paid. A BCBSUW official attributed the condition to the claims reviewer's oversight in not submitting the claim to edit checks. Regarding the other account, the hospital erroneously billed the claim under its general provider number and a year later submitted another claim using a specialty provider number.

Regardless of type, our review disclosed that the Medicare overpayments remained on the hospitals' accounting records for periods in excess of one year because (1) hospitals did not routinely prepare follow-up adjustment forms when the initial adjustments were not recovered by BCBSUW in a timely manner, (2) BCBSUW did not have adequate provider audit reviews to monitor provider compliance with credit balance requirements, and (3) BCBSUW did not process adjustments submitted by the hospital within a reasonable time frame. These conditions are discussed in more detail in the following paragraphs of the report.

HOSPITAL REVIEWS OF CREDIT BALANCES

Our review showed that the eight hospitals had identified 92 percent of the accounts with overpayments and submitted at least one adjustment form to BCBSUW by the time of our audit field work. The remaining 8 percent of the accounts, applicable to five hospitals, represent only $5,102 of the $197,577 in overpayments.

Although the hospitals generally identified the overpayments and submitted adjustments, we found that seven of the eight hospitals did not have formal or written policies and procedures to periodically review the credit balance accounts and to follow-up on adjustments which were not processed within a reasonable time. In fact, officials from three hospitals stated they were unaware of the Federal requirement to refund overpayments within 60 days. As a result of these conditions, inpatient credit balances remained on the accounting records of the eight hospitals for an average of 399 days while outpatient credit balances were retained an average of 424 days from the time the hospital identified the overpayment.

INTERMEDIARY AUDITS OF CREDIT BALANCES

While the hospitals are primarily responsible for refunding the Medicare overpayments, BCBSUW is responsible for ensuring that hospitals comply with Medicare regulations. The BCBSUW Provider Audit Unit (PAU) performs audits of hospital cost reports, including audit field work at selected hospitals. We were advised that the PAU does not perform field audits at every hospital every year because of fiscal constraints imposed by the Medicare budget.

We found that the scope and extent of the PAU audits were too limited to identify a significant number of credit balances. Our review of the PAU procedures disclosed that the credit balance portion of their audit program generally relates to MSP credit balances. The audit program instructed the PAU auditors to obtain the hospital's credit balance listings, inquire whether the provider had submitted adjustment forms for overpayments and obtain written policies and procedures from hospital officials.

Our review of the PAU workpapers for two sample hospitals confirmed that, while credit balance listings were obtained, there was no verification of the information obtained. We also noted that certain information necessary to make adjustments was not obtained on the credit listings, i.e., HIC numbers, dates of service, remittance advice information, etc. As a result, even though the credit balance information was obtained and provided to the BCBSUW MSP and adjustment units, it was generally not useful in the recovery of Medicare overpayments.

Our review showed that, in fiscal year 1991, the PAU performed field audits at three of our eight sample hospitals while, in fiscal year

1990, five of our eight hospitals were audited. Since the cost reporting periods audited ranged from fiscal years ending December 31, 1987 through December 31, 1988, the PAU did not review the same credit balance information we examined.

With the limited number of field audits performed, the audit process itself cannot be relied upon to detect all Medicare credit balances and overpayments that were not refunded by the hospitals. However, we believe that periodic audits can provide a degree of assurance that hospitals, at a minimum, have procedures in place to review Medicare credit balance accounts for purposes of identifying overpayments and are complying with their procedures.

INTERMEDIARY ADJUSTMENT PROCESSING

Although the eight hospitals in our sample submitted adjustments to BCBSUW to correct the overpayments, we found that BCBSUW generally did not process the adjustments in a timely manner. Our review disclosed that the average inventory of pending adjustments at BCBSUW for calendar years 1988 through 1990 were as follows:

	Adjustments Pending	
Year	At Year End	Monthly Average
1988	6,464	6,155
1989	4,724	7,333
1990	9,515	7,960

At the end of June 1991, there were 2,553 unprocessed adjustments and the monthly average of pending adjustments for the first six months of 1991 was reduced to 5,242.

In our opinion, adjustments were not processed in a timely manner because, as disclosed in our review, BCBSUW does not maintain adequate controls over all unprocessed adjustments submitted by providers. The MSP unit adequately controlled MSP adjustments received, processed and pending through the use of a control log. However, for the non-MSP adjustments, BCBSUW had no system to record and account for individual adjustments received, processed and pending. Upon receipt, the hard copies of the non-MSP adjustments were distributed to personnel which were responsible for specific types of providers, i.e., hospital inpatient, hospital outpatient, skilled nursing facilities, home health agencies, etc. The interval between the receipt of the adjustment and completion of the processing can be as much as one year based on the results of our hospital audits. During this interval of time, BCBSUW has no record or method to locate the adjustments in process.

BCBSUW representatives attributed the backlog of pending adjustments to the higher priority BCBSUW gave to processing claims (because HCFA reviews their performance annually) and insufficient staffing due to a lack of funding for adjustments staff and high personnel turnover.

The HCFA is aware of the general 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.

CONCLUSIONS AND RECOMMENDATIONS

CONCLUSIONS

Based on our examination of eight hospitals, we believe that, similar to the hospitals reviewed, many other Wisconsin hospitals do not have policies and procedures to routinely review credit balances and periodically follow-up on refund requests which are not processed in a timely manner. Such credit balance reviews are warranted since we estimate that 34 Wisconsin hospitals retained Medicare overpayments of $919,826 for an average of more than one year.

In our opinion, improvements are also needed at BCBSUW if Medicare overpayments are to be identified and recovered in a timely manner. The reviews performed by BCBSUW's PAU did not adequately monitor credit balances because the auditors: (1) examined only a small number of hospitals each year, (2) reviewed primarily MSP related information, (3) did little or no verification of the credit balance information, and (4) obtained credit balance listings which did not contain sufficient information to process recovery adjustments.

Further, our audit disclosed that a significant number of adjustments were pending because BCBSUW placed a low priority on processing adjustments, and until recently, BCBSUW did not have an inventory control system for non-MSP adjustments. During our audit, HCFA reached a similar conclusion and directed all intermediaries to implement controls over provider adjustments from receipt to resolution, beginning January 1, 1992. We have, therefore, taken the HCFA requirements into consideration in making our recommendations to BCBSUW.

RECOMMENDATIONS

We recommend that BCBSUW:

1) Direct providers to:

   (a) implement procedures to identify and review Medicare credit balances,

   (b) notify BCBSUW within 60 days when Medicare adjustments are due, and

   (c) follow-up with BCBSUW when adjustments are not processed in a timely manner.

2) Direct their PAU to:

   (a) expand the scope of its audit program to include steps for the detection of Medicare overpayments other than just MSP overpayments, and

(b) define the credit balance information needed from providers to ensure that sufficient detail is present to take recovery action.

3) Eliminate the remaining backlog of unprocessed hospital adjustments and ensure that future adjustments are processed in a timely manner.

4) Ensure that the eight hospitals identified in this report comply with the procedural recommendations made in each individual audit report and refund the $197,577 in Medicare overpayments that were identified.

BCBSUW COMMENTS

BCBSUW officials generally concurred with our findings and indicated they have taken corrective action on three of our four recommendations. On June 7 and October 30, 1991, BCBSUW notified all providers that they are responsible for identifying and refunding Medicare credit balances within 60 days. BCBSUW officials stated that providers were previously instructed to use a tracer procedure, dated August 1990, to follow-up on adjustments which were not processed in a timely manner. BCBSUW's backlog of hospital adjustments has reportedly been reduced to one month's work on hand and, in response to HCFA's September 26, 1991 letter, they have now initiated internal procedures to better control adjustment requests received from providers. BCBSUW officials also stated that they were taking appropriate steps to recover the $197,577 in Medicare overpayments. BCBSUW indicated that as of March 20, 1992, $155,119 has been recovered from the eight hospitals reviewed.

BCBSUW officials did not agree with our recommendation to expand the scope of its provider audits. They felt that provider audits are not an effective way to monitor provider compliance with the federal requirements for refunding overpayments because of the small number of audits performed per year. Currently, BCBSUW auditors verify only that providers have procedures in place to identify and report credit balances.

OIG COMMENTS

Since HCFA has rescinded its quarterly credit balance reporting requirements and BCBSUW has further reduced the scope of its provider audits, we believe there are no controls currently in place to ensure that providers comply with Federal regulations to refund Medicare overpayments within 60 days. We continue to believe that, as a minimum, provider audits should include reviews of credit balances to determine if Medicare overpayments exist and what action the provider has taken to refund the overpayments.

APPENDICES

APPENDIX A

INPATIENT CREDIT BALANCES
RESULTS OF HOSPITAL REVIEWS

Hospital	Number of Credit Balances Reviewed	Overpayments No.	Overpayments Amount	Average Number of Days
St. Francis Hospital	3	0	$ 0	N/A
St. Joseph's Hospital	4	2	4,956	353
Sacred Heart Hospital	12	0	0	N/A
Sinai Samaritan Medical Center	48	17	60,623	392
Meriter Hospital	16	8	30,379	238
Trinity Memorial Hospital	7	5	13,298	521
St. Catherine's Hospital	18	7	25,181	622
St. Luke's Hospital	9	8	28,886	314
Totals	117	47	$163,323	399

APPENDIX B

OUTPATIENT CREDIT BALANCES
RESULTS OF HOSPITAL REVIEWS

Hospital	Number of Credit Balances Reviewed	Overpayments		Average Number of Days
		No.	Amount	
St. Francis Hospital	8	2	$ 245	517
St. Joseph's Hospital	24	9	2,816	335
Sacred Heart Hospital	50	0	0	N/A
Sinai Samaritan Medical Center	101	27	15,565	444
Meriter Hospital	103	19	7,427	214
Trinity Memorial Hospital	16	3	836	401
St. Catherine's Hospital	100	19	4,378	633
St. Luke's Hospital	30	9	2,987	442
Totals	432	88	$ 34,254	424

APPENDIX C

BCBSUW WRITTEN COMMENTS

Blue Cross &
Blue Shield
United of Wisconsin

Federal Medicare
Intermediary

Medicare

1515 North RiverCenter Drive
P.O. Box 2019
Milwaukee, WI 53212-2019
414/226-5000

March 20, 1992

Martin D. Stanton
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
105 W. Adams Street
Chicago, IL 60603-6201

Dear Mr. Stanton:

Thank you for giving us the opportunity to provide written comments on the draft audit report (Common Identification Number A-05-91-00128) reviewing our procedures for handling hospital credit balances. Following are our comments on the specific recommendations included in the report.

1)(a) We recommend that BC/BSUW direct providers to implement procedures to identify and review Medicare credit balances.

1)(b) We recommend that BC/BSUW direct providers to notify BC/BSUW within 60 days when Medicare adjustments are due.

Recommendations 1)(a) and 1)(b) were both addressed in our memorandum to all providers dated June 7, 1991 (Copy attached). The memorandum directed providers to identify credit balances and report them to us in quarterly reports. The memorandum also reminded providers of their obligation under 42 CFR 489.20 which requires providers to refund to Medicare any amounts overpaid within 60 days of identification of the overpayment.

We were subsequently directed to suspend the requirement that providers submit quarterly reports of Medicare credit balances. We communicated this to providers in a general communication dated October 30, 1991 (Copy attached). In this memorandum we emphasized that the suspension of quarterly reporting did not relieve providers of their responsibility to identify and report credit balances.

1)(c) We recommend that BC/BSUW direct providers to follow-up with BC/BSUW when adjustments are not processed in a timely manner.

We have a procedure in place for providers to follow-up on claims or adjustments which have not been processed. This procedure has been communicated to all providers. Providers have been instructed to complete the Medicare Provider Tracer Form (Copy attached) and submit it to our office when a claim or adjustment is not processed in a timely manner. Instructions for completion of this form and a copy of the form are included in provider training manuals given to all providers.

2)(a) We recommend that BC/BSUW direct their Provider Audit unit to expand the scope of its audit program to include steps for the detection of Medicare overpayments other than just MSP overpayments.

When HCFA instituted quarterly credit balance reporting for providers, our Provider Audit area eliminated all steps associated with credit balances from their audit program except for verification that the provider has procedures in place to identify and report Medicare credit balances. Our current audit program does not include steps to detect Medicare overpayments.

Expansion of the scope of our audit program to include detection of Medicare overpayments would not be an effective method of monitoring provider compliance in this area due to the limited number of hospital audits performed. During fiscal year 1992, we are funded to perform audits for only 12, or approximately 8%, of the hospitals we serve as a Medicare intermediary.

The draft audit report recognizes this fact where it states on page 7 that "With the limited number of field audits performed, the audit process itself cannot be relied upon to detect all Medicare credit balances and overpayments that were not refunded by the hospitals. However, we believe that periodic audits can provide a degree of assurance that hospitals, at a minimum, have procedures in place to review Medicare credit balance accounts for purposes of identifying overpayments and are complying with their procedures."

2)(b) We recommend that BC/BSUW direct their Provider Audit unit to define the credit balance information needed from providers to ensure that sufficient detail is present to take recovery action.

The credit balance information needed from providers was defined in the memorandum dated June 7, 1991 regarding Medicare credit balances referred to in response to 1)(a) and 1)(b) above. We are no longer requesting this information from providers as part of our audit, as discussed in our response to 2)(a) above.

3) We recommend that BC/BSUW eliminate the remaining backlog of unprocessed hospital adjustments and ensure that future adjustments are processed in a timely manner.

HCFA's letter dated September 26, 1991, which is referred to in the audit report, directed us to implement controls for all provider submitted adjustments and reduce our backlog to 2 month's work on hand by March 1992. Our February 1992 Medicare Program Intermediary Workload Report shows that 5,496 adjustments were processed during February and the balance of adjustments pending is 5,513, one month's work on hand. We have surpassed HCFA's requirement for working down the backlog of adjustments.

We have also initiated internal procedures to better control provider submitted adjustments. Tracking of provider submitted adjustments now begins when the adjustments are assigned document control numbers upon receipt. The document control number allows us to control adjustments based on provider type and date of receipt. Adjustments are worked on a daily basis along with original claims workload on a first in-first out basis.

4) We recommend that BC/BSUW ensure that the eight hospitals identified in this report comply with the procedural recommendations made in each individual audit report and refund the $197,577 in Medicare overpayments that were identified.

Our current audit procedures would verify that the hospitals reviewed have procedures in place to identify and report Medicare credit balances.

When the OIG staff was in our office performing their review, we requested a listing supporting the $197,577 in Medicare overpayments which they had identified in their review of the eight hospitals. We have received this listing and are taking the appropriate steps to recover the amounts owed the program. As of the date of this letter, we had recovered $155,119 of the $197,577 outstanding.

We see no reason to hold an exit conference to discuss the issues presented in the draft audit report. If you or your staff have any questions on our responses to the recommendations, please have them contact Mary Flaschner, Manager - Government Accounting and Contract Administration at (414)226-5588.

Sincerely,

C. Edward Stephens

C. Edward Stephens
Vice President
Government Programs

cc: Cynthia Owens, OIG - Madison
Carol Ressmeyer, HCFA - Chicago
Jack Zaban, HCFA - Chicago

Blue Cross &
Blue Shield
United of Wisconsin

Federal Medicare
Intermediary

Medicare

1515 North RiverCenter Drive
P. O. Box 2025
Milwaukee, WI 53212-2025
414/226-5000

TO: Administrator/CEO
FROM: Mary S. Flaschner, Manager-Government Accounting and Contract Administration
DATE: June 7, 1991
SUBJECT: Medicare Credit Balances

Recently, the Health Care Financing Administration (HCFA) advised each of its intermediaries of a problem concerning credit balances at providers participating in the Medicare program. In part, HCFA explained that some providers have not been returning monies due to Medicare, which result from duplicate billings or Medicare Secondary Payor (MSP) requirements.

We would like to remind you that, as a condition of participation in the Medicare program, the regulations issued October 11, 1989, at 42 CFR 489.20 require providers to:

> Utilize admission procedures that identify primary payers other than Medicare, so that incorrect billings and Medicare overpayments can be prevented.
>
> Bill the primary payers before Medicare, except in certain liability situations.
>
> Reimburse Medicare any overpaid amount, within 60 days, if payment is received from both Medicare and another payer.

In order to help resolve the inappropriate accumulation of Medicare credit balance funds, HCFA has directed us to take specific actions which affect your operations. First, we will control adjustment claims more closely. This will help to ensure that refunds made by providers, via adjustment bills, are retained if the adjustment bills fail claims system edits. Next, we will accept checks submitted by providers for the repayment of credit balances. Finally, we are requiring all providers to submit detailed listings of their Medicare credit balances, on a quarterly basis.

To determine whether a refund is owed to Medicare, the beneficiary, or another health insurer, reference should be made to Section 300 of the Medicare Hospital Manual, which pertains to eligibility, and to the MSP admissions procedures contained in Section 301 of the Hospital Manual.

You are to prepare a listing which provides all of the following data for each credit balance due to Medicare. Do not include credit balances due to other payers.

* Patient/Beneficiary Name
* Health Insurance Claim Number
* ICN of the original paid claim
* Admission Date and Discharge Date (For outpatient services, the From and Through Dates.)
* Whether the service is in a closed cost report period or an open period. Adjustment bills will not be required for closed cost report periods. Adjustment bills are required for open cost report periods.
* If an adjustment bill has been submitted. If not attach the adjustment.
* Amount owed to Medicare
* Reason for the Credit (e.g., duplicate of payment previously received from Medicare, another payer paid for the same services, etc.)
* Identification of the payer if another payer paid
* Reason for the Credit Balance (e.g., adjustment bill sent to Medicare but failed intermediary's edits, check returned by Medicare for additional information, never reported, etc.)
* Indicate whether the individual item is included in the check that you attach as described below or if money has been sent previously to Medicare.

The listing, which constitutes the first quarterly report, is to be submitted to this office by June 30, 1991. This will be a cumulative report through March 31, 1991. Include all monies due to Medicare for credit balances identified as of the end of the first calendar quarter of 1991, which have not subsequently been cleared by a processed adjustment, in this report. This includes the cumulative amount (or balance) for all prior periods. Subsequent quarterly reports will cover three months inclusive and are due in this office at the end of the month following the end of the quarter. For example, the March-June report is due July 31, 1991. In addition, you are to attach a check to the report. This check must represent the total amount summarized for claims for closed cost report periods in the listing. Should the first report indicate such large amounts of money due to Medicare that payment would create a hardship, contact this office immediately to arrange a repayment schedule. Your call or letter should be addressed to:

Mary S. Flaschner
Manager-Government Accounting and Contract Administration
Blue Cross & Blue Shield United of Wisconsin
1515 North RiverCenter Drive
Milwaukee, WI 53212

(414) 226-5588

We anticipate no problems after the first report and associated refund, as you will then be current in reporting and refunding Medicare credit balances.

MEDICARE MEMO

DATE: October 30, 1991

TO: Hospital Business Office Managers

RE: Multiple Issues

It is very important that this Medicare Memo gets circulated to all affected areas within your facility. Many varied issues and implementation dates are addressed.

OBRA 1990 Changes Effective 10/01/91

The OBRA 1990 instructions regarding the inclusion of all related services provided by the admitting hospital within 3 days prior to the date of admission on the inpatient bill, originally scheduled to go in effect on 10/1/91, have been put on hold by HCFA.

The current 72 hour diagnostic services rule, as well as the current 24 hour all outpatient services rule will remain unchanged. It is not anticipated that we will have further instruction until at least January 1, 1992.

OBRA 1990 - Amendments to ESRD-MSP Provision

In general, the amendments made by OBRA 90 make Medicare the secondary payer during the first 18 months of an individual's Part A entitlement based solely on ESRD. (Where there is a 3-month waiting period before Medicare Part A eligibility or entitlement begins, employer group health plans (EGHPs) will be primary payers for 21 months - the 3 month waiting period plus the first 18 months of the individuals entitlement to or eligibility for Medicare Part A.)

Individuals who were in a 12-month period under prior law, and for whom an EGHP was therefore the primary payer, on November 5, 1990, are affected by these changes. Individuals whose 12-month periods under prior law ended on October 31, 1990 or earlier are not affected by these changes.

The Medicare Memo is published by:

Blue Cross & Blue Shield
United of Wisconsin

A91-013

1515 North RiverCenter Drive
Milwaukee, Wisconsin 53212

Use of Nine Diagnosis and Six Procedure Codes

Hospitals may report up to nine diagnoses and six procedures beginning October 1, 1991; but are not required to report in excess of five diagnoses and three procedures until April 1, 1992.

The current UB-82 form provides for a "Principal Diagnosis Code" in locator 77, an four additional "Other Diagnosis Codes" in locators 78 through 81; a "Principal Procedure" and date in locator 84, and space for two "Other Procedures" and dates in locators 85 and 86.

Report overflow information (e.g. additional diagnosis codes, procedure codes) in locator 94, "Remarks" using the following standard format.

a. Code "FL" to indicate form locator number.
b. Provide appropriate code number, followed by a colon.
c. Provide appropriate code, and/or date.
d. Separate multiple entries with a semicolon ";".
e. Format example:
   -diagnosis code: FL 81: 0389; 5990
   -procedure code: FL 86: 8879, 10011; 8703, 10011

Remittance Advice Changes

Effective immediately we are implementing a new method of informing you of medical review denials for Outpatient claims on your Remittance Advice (R.A.). Previously we reported a disapproval (DAP) code in the rejection code field of the R.A. The rejection code field will continue to be used for the reporting of system generated and claims review DAP codes (e.g. 90R, 91R, F01, etc.).

Medical Review denial codes will now be reported in the Denial Code (DC) field on the R.A. The DC code is exactly the same as the previous Medical Review DAP codes, except the F or P prefix and narrative will not appear. You must consult the listing of DAP codes provided in your ACPS Training Manual to obtain the narrative explanation corresponding with the DC on the R.A.

Mammography Billing Update

We have been received many inquiries relating to the billing of screening and diagnostic mammographies. As a result, a brief explanation of billing requirements for both types of mammographies follows:

Screening Mammography - Bill Type - Must be 14X
Revenue Code - Must be 403
HCPCS Code - Must be 76092
Use Diagnosis code V761 or a high risk diagnosis.

Important: Screening mammography charges must be billed alone on the UB-82.

Diagnostic Mammography - Bill Type - Can be 13X, or 14X
Revenue Code - Must be 401
HCPCS Code - Must be 76091
A Medically related diagnosis code is required, preferably in Principal Diagnosis field on UB-82.

If the above conditions are not met we will return your claim to you on the Bill Error Document (BED) report. If the claim is returned to us with a similar error we will deny the claim as "services not covered under Medicare."

Note: Providers that perform screening mammographies must request and be certified by the state bureau of compliance before payment can be made.

EPO Update

In a reiteration of the 2/15/91 Medicare Memo regarding the billing of Value Code 68 for EPO units administered; the Value Code field is not a monetary field for Value Code 68 and the dotted line should not be considered a decimal delimiter. All values should be entered to the far right of the "amount" part of the Value Code field, with no zero filling.

10/1/91 ICD9-CM Coding Changes

Attached to this memo is a copy of the 10/1/91 ICD9-CM coding changes. All of these changes are included in Outpatient Code Editor (OCE) 7.0, Medicare Code Editor (MCE) 8.0, and Grouper 9.0, that we are using as of 10/1/91.

Billing for Conditional Payment

If Medicare is not the primary payer on a claim, and the primary payer refuses to pay the charges, do not submit a demand bill. The proper way of billing is to submit a conditional payment claim, with Medicare listed as secondary, the proper Value Code, and zeros as the amount the primary payer paid. Medicare will then investigate as to why the primary payer refuses to pay.

Sending Checks to Medicare

When sending checks to the Medicare Program, please indicate on the check which department you intend the check to go to. Examples may be Medicare Secondary Payer (MSP) or Provider Audit. Using this procedure will prevent the misrouting of checks within Medicare.

Expanded Use of HCPCS Coding

Effective with Dates of Service beginning 10/16/91, HCPCS coding has been expanded for Outpatient services as explained in Medicare Hospital Manual Transmittal 619 (August 1991). Some clarifications to transmittal 619 are as follows:

- Hospitals code the drugs administered during Chemotherapy using HCPCS codes under revenue code 636. The definition of the HCPCS code specifies the lowest common denominator of the amount of the dosage. Hospitals utilize the units field as a multiplier to arrive at the dosage amount. For Example, J9045 contains a dosage of 50 mg. For a total dosage of 150 mg. show 3 in the units field (UB-82 locator 52).

- Add J9202 - Goserelin Acetate Implant per 2.6 mg.
  Add J9217 - Lueprolide Acetate for Depo Suspension, 7.5 mg.
  to the list of Chemotherapy drugs

- Remove J9160 - Delautin, 1cc, 250 mg.
  from the list of Chemotherapy drugs

- Revenue Code 276 has been added to the list of Revenue Codes not requiring HCPCS.

The following edits are effective with dates of service beginning 10/16/91:

Edit 450 - Invalid type "Misc" HCPCS Code.

For Rev. Codes	Claim TOB	HCPCS Must Be
260,269	13X,71X,83X	Q0081
331,332,335	13X,14X,71X,83X	Q0083,Q0084,Q0085
42X	13X,71X,83X	Q0086
43X	13X,71X,83X	H5300
53X	13X,71X	Q0082
902,903	13X,71X,83X	Q0082

Edit 451 - Invalid HCPCS for Rev Code 636

Valid HCPCS are: J9000, J9010, J9020, J9030, J9040, J9045, J9050, J9060, J9062, J9070, J9080, J9090, J9091, J9097, J9100, J9110, J9120, J9130, J9140, J9150, J9165, J9170, J9181, J9182, J9190, J9200, J9202, J9208, J9209, J9212, J9217, J9218, J9230, J9240, J9250, J9260, J9270, J9280, J9290, J9291, J9293, J9295, J9300, J9320, J9340, J9360, J9370, J9375, J9380, J9999.

Edit 452 - Invalid Type "Other" HCPCS

For Rev. Codes	Claim TOB	HCPCS Must Be
44X, 47X	13X,71X,83X	In Range 92502-94799
901	13X,71X,83X	90870 or 90871
917	13X,71X,83X	In Range 90900-90915
924	13X,71X,83X	90000 or In Ranges 95000-95082 or 95115-95199

Edit 453 - Invalid Type "Other" HCPCS

For Rev. Codes	Claim TOB	HCPCS Must Be
900,909,910-916, 918 and 919	13X,71X,83X	90801, or in Ranges 90825-90862 or 90880-90899

Note: These Edits should be added to your current list of ACPS LIMO edits.

Medicare Credit Balance Reporting

HCFA has been directed to suspend the requirement that providers report Medicare credit balances on a quarterly basis until formal approval is obtained from the Executive Office of Management and Budget (OMB). Therefore, providers are not required to submit credit balance reports until further notice is received. Suspension of the credit balance reporting requirements does not relieve providers of their responsibility to repay HCFA for any improper Medicare program payment. Providers are expected to continue to identify Medicare credit balances and to submit adjustment bills. Where adjustment bills were previously sent to the Intermediary, but returned to the provider because they failed processing edits, the provider should correct and resubmit the bills timely.

Final Settlement, Temporary Settlement and Lump Sum Adjustment Letters

In the past, our Medicare letters for underpayments included the date of payment. Effective immediately, we have changed our letter to read that the underpayment will be reviewed for offsets against other Medicare liabilities. If none exist, payment will be made within 30 days of the date of that letter.

Notice of Interest Rate for Overpayments and Underpayments

On July 10, 1991, the Federal Register (Vol. 56, No. 132) published a final rule entitled "Changes Concerning Interest Rate Charged on Overpayments and Underpayments". The revised Medicare regulation provides for the assessment of the higher of either the private consumer rate (PCR) or the current value of funds rate of interest on overpayments and underpayments.

This final rule is effective August 9, 1991, and any final determinations made on or after that date will be subject to the higher of the two rates. The PCR is currently 15 1/8 percent.

If you have any questions regarding this memo, please call Provider Education at (414) 226-6075.

Attachment

August, 1990

Medicare Blue Cross & Blue Shield United of Wisconsin
1515 N. RiverCenter Drive
Milwaukee, Wisconsin 53212

MEDICARE PROVIDER TRACER FORM

PROVIDER NUMBER: _____

PROVIDER NAME: _____

DATE: _____

REASON FOR INQUIRY: _____

____ Claim Status
____ Adjustment Status
____ Other: _____

RESPONSE: _____ DATE: _____

In order to process your inquiry the following information is necessary:

____ Provider name and number.
____ Beneficiary HI # as it appears on Medicare card.
____ Beneficiary name as it appears on Medicare card.
____ Date of service.
____ Correct payer in Locator 57.
____ Other: _____

We have researched the attached claim. The status of the bill is as follows:

____ We have no record of the bill indicated by the attached copy. It will be necessary for you to submit an original UB-82 bill for processing.
____ See your remittance advice dated _____.
____ The claim in question was processed _____. Check your remittance advice following this date.
____ The attached bill is pending for a medical review determination.
____ The attached bill is pending for WIPRO review.
____ The attached bill is pending for review.
____ The attached bill is waiting for additional information. If the information is not received within 30 days of the request, the claim will be denied.
____ The attached bill is currently in the query process.
____ The attached bill has been forwarded to Medicare Adjustments for processing.
____ Other: _____

Signed: _____

INSTRUCTIONS FOR COMPLETING TRACER FORM

A. Complete:

1. Provider number
2. Provider name
3. Date

B. Reason for Inquiry:

1. Check to receive status of claims eligible for tracing.
2. Check for status of an adjustment claim.
3. Check for additional clarification.

C. Response:

1. Provider does not complete. This is for Medicare's response to your inquiry.

CLAIMS ELIGIBLE FOR TRACING HAVE TO BE EITHER:

1. "Clean" (no development needed) where a minimum of 30 days have elapsed from date of submission.
2. "Other" (development needed) where a minimum of 60 days have elapsed from date of submission.

Providers utilizing the Medicare Data Acquisition Terminal should use the HICN feature to trace a claim instead of submitting paper tracers.

If a claim qualifies in either of the above categories:

Send a photocopy of the UB-82 bill with "TRACER" clearly marked across it.

Mail to: Medicare Services
P.O. Box 2019
Milwaukee, WI 53201

New York and New Jersey Providers Mail to:

Medicare Services
100-2 Summit Lake Dr.
Valhalla, NY 10595