DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, Texas 75242

Report Number: A-06-07-00054 April 12, 2007

Ms. Gerri Webb
Vice President
Government Programs
Chisholm Administrative Services
1215 S. Boulder
Tulsa, OK 74119-2800

Dear Ms. Webb:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' (OAS) report entitled "Review of Excessive Payments for Outpatient Services Processed by Chisholm Administrative Services." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. § 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available 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 Report Number A-06-07-00054 in all correspondence relating to this report.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:
James R. Farris
Regional Administrator
Centers for Medicare & Medicaid Services, Region VI
1301 Young St., Suite 714
Dallas, TX 75202

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF EXCESSIVE PAYMENTS FOR OUTPATIENT SERVICES PROCESSED BY CHISHOLM ADMINISTRATIVE SERVICES

Daniel R. Levinson
Inspector General

April 2007
A-06-07-00054

Office of Inspector General

http://oig.hhs.gov

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

Chisholm Administrative Services (Chisholm) has been a Medicare Part A intermediary serving Medicare providers in Oklahoma, including more than 150 hospitals. For claims with dates of service in calendar year 2003 and 2004, Chisholm processed 14 outpatient claims that had payments of $50,000 or more.

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that Chisholm made to providers for outpatient services were appropriate.

SUMMARY OF FINDING

All of the high-dollar Medicare outpatient payments were not appropriate. For calendar year 2003 and 2004 claims, Chisholm made 14 payments of $50,000 or more each for outpatient services. Our analysis indicated that, at the start of our fieldwork in February 2007:

- Eight of the payments were incorrect, and the providers had refunded the $494,497 in overpayments.

- Six additional payments were incorrect, but the provider had not refunded the $514,323 in overpayments.

Contrary to Federal guidance, the providers inappropriately overstated the units of service in each of the 14 high-dollar claims. Chisholm made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar year 2003 or 2004 to detect billing errors related to units of service.

RECOMMENDATIONS

We recommend that Chisholm:

- inform us of the status of the recovery of the $514,323 in overpayments that our audit identified and

- use the results of this audit in its provider education activities.

CHISHOLM ADMINISTRATIVE SERVICES'S RESPONSE

Chisholm agreed with our report findings and recommendations. Chisholm stated that it has already recovered the overpayments identified in the report and will provide further education regarding the proper billing units for outpatient services.

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INTRODUCTION

BACKGROUND

Fiscal Intermediary Responsibilities

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A and provider Part B claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for Outpatient Services

Claims for outpatient services originate at the providers. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed. To process providers' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System as well as CMS's Common Working File. The Common Working File can detect certain improper payments when processing claims for prepayment validation.

In calendar years 2003 and 2004, providers submitted approximately 268 million outpatient claims. Of these 268 million claims, only 842 claims resulted in payments of $50,000 or more. We considered such claims to be at high risk for overpayment.

Chisholm

Chisholm Administrative Services (Chisholm) has been a Medicare Part A intermediary serving Medicare providers in Oklahoma, including more than 150 hospitals. For claims with dates of service in calendar year 2003 and 2004, Chisholm processed 14 outpatient claims that had payments of $50,000 or more.

The Social Security Act's definition of "provider of services" encompasses hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, renal dialysis facilities, and hospice programs. However, all providers with claims exceeding $50,000 processed by Chisholm were hospitals; thus, the term "provider" as used in the remainder of this report refers to hospitals.

New Fiscal Intermediary Prepayment Edit

On January 3, 2006, after the end of our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends outpatient claims of $50,000 or more and requires intermediaries to contact providers to determine the legitimacy of the claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that Chisholm made to providers for outpatient services were appropriate.

Scope

We reviewed the 14 outpatient claims for which Chisholm paid $50,000 or more in calendar years 2003 and 2004. We limited our review of Chisholm's internal control structure to those controls applicable to the 14 claims because our objective did not require an understanding of all internal controls over claims submission or claims processing. Our review allowed us to establish a reasonable assurance regarding the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our fieldwork at Chisholm's office in Tulsa, Oklahoma, during February 2007.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- used CMS's National Claims History file to identify outpatient claims with Medicare payments of $50,000 or more;

- reviewed available Common Working File claims histories for claims of $50,000 or more to determine whether those claims had been canceled and superseded by a revised claim or whether the payments remained outstanding at the time of our fieldwork;

- contacted the providers with outstanding payments to determine whether the units of service shown on the claims were correct and, if not, why the claims were billed in error and whether the providers agreed that a refund was appropriate; and

- coordinated our review with Chisholm.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDING AND RECOMMENDATIONS

All of the high-dollar Medicare outpatient payments were not appropriate. For calendar year 2003 and 2004 claims, Chisholm made 14 payments of $50,000 or more each for outpatient services. Our analysis indicated that, at the start of our fieldwork in February 2007:

- Eight of the payments were incorrect, and the providers had refunded the $497,497 in overpayments.

- Six additional payments were incorrect, but the provider had not refunded the $514,323 in overpayments.

Contrary to Federal guidance, the providers inappropriately overstated the units of service in each of the 14 high-dollar claims. Chisholm made these overpayments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in calendar year 2003 or 2004 to detect billing errors related to units of service.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). Section 3627.8(C) of the "Medicare Intermediary Manual" states: "The definition of service units is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the 'number of times the service or procedure being reported was performed.'" Furthermore, the "Hospital Manual," section 462, states: "In order to be paid correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE CLAIMS SUBMISSIONS

All 14 claims for $50,000 or more resulted in inappropriate payments. Two providers billed incorrect and excessive units of service.

- In five instances, one provider incorrectly billed several injectable drug codes. As of our fieldwork date, the provider had already refunded all five claims.

- In nine instances, one provider billed incorrect and excessive units of service for one drug, Epoetin. In each case, the provider billed the dosage strength instead of the correct billing units, which was 1 unit per 1,000 dosage strength. For example, instead of billing 8 units, the provider billed 8,000 units. As of our fieldwork date, the provider had already refunded three of the nine claims.

Our analysis showed that the 14 outpatient claims for calendar years 2003 and 2004 contained overpayments totaling $1,011,820. As of the February 2007 start of our fieldwork, the providers had refunded eight overpayments totaling $497,497. We gave the remaining six claims, which accounted for $514,323 of the total overpayments, to both Chisholm and the provider for correction.

CAUSES OF OVERPAYMENTS

The providers agreed that overpayments occurred on the claims and that a refund was due or has already been made. The provider attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent incorrect billing of units of service.

In addition, during calendar years 2003 and 2004, Chisholm did not have prepayment or postpayment controls to identify aberrant payments at the claim level and the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments to providers. In effect, Medicare relied on providers to notify the intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments made to providers.

RECOMMENDATIONS

We recommend that Chisholm:

- inform us of the status of the recovery of the $514,323 in overpayments that our audit identified and

- use the results of this audit in its provider education activities.

CHISHOLM ADMINISTRATIVE SERVICES'S RESPONSE

Chisholm agreed with our report findings and recommendations. Chisholm stated that it has already recovered the overpayments identified in the report and will provide further education regarding the proper billing units for outpatient services.

APPENDIX

Chisholm Administrative Services

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CMS
CENTERS for MEDICARE & MEDICAID SERVICES

March 29, 2007

Gordon L. Sato
Regional Inspector General for Audit Services
Department of Health & Human Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

RE: Response to Draft Report Number A-06-07-00054

Dear Mr. Sato,

Thank you for the opportunity to review the referenced draft report "Review of Excessive Payments for Outpatient Services Processes by Chisholm Administrative Services."

We agree with the recommendations. We have already recovered the overpayments identified in the report and will provide further provider education regarding the proper billing of units for outpatient services. In addition, as noted in the report, claims edits were installed in January 2006 that suspend outpatient claims of $50,000 or more for further review and contact with the providers to determine the legitimacy of the claims.

Also, the provider with the majority of improperly billed claims reviewed their claim history and corrected additional claims with overpayments under $50,000.

If you have any additional questions or concerns, contact Tamarcia Woodard, Claims Manager, 918-551-2072 or Pam Beene, Claims Supervisor, 918-551-2531.

Sincerely,

Garoldine Y. Webb
Sr. Director, Medicare Operations

cc: Mark Smith, Medicare CFO
Tracy McKenzie, Internal Audit