DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

March 25, 2008

Report Number: A-06-07-00083

Mr. Jimmy Chaney
Director of Medical Claims
TriSpan Health Services
1064 Flynt Drive
Flowood, Mississippi 39232-9750

Dear Mr. Chaney:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Medicare Part A Claims Processed by TriSpan Health Services for the Period January 1, 2003, Through December 31, 2003." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-07-00083 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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Acting Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE PART A CLAIMS PROCESSED BY TRISPAN HEALTH SERVICES FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

March 2008
A-06-07-00083

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. ' 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer the Medicare Part A program. 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.

Providers generate the claims for inpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (the PPS). Under the PPS, claims are paid a predetermined amount based on a patient's placement into a specific diagnosis-related group and an additional amount, known as an outlier, for stays that have extraordinarily high costs.

To process providers' inpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

TriSpan Health Services (TriSpan) is a Medicare Part A intermediary serving more than 1,800 Medicare providers in Mississippi, Louisiana, and Missouri. During calendar year (CY) 2003, TriSpan processed 401,754 inpatient claims, 38 of which resulted in payments of $200,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether TriSpan's high-dollar Medicare payments to Part A providers for inpatient services were appropriate.

SUMMARY OF FINDINGS

Eighteen of the 38 high-dollar payments that TriSpan made to providers were appropriate. However, TriSpan incorrectly paid providers for 20 claims. For 17 of the 20 claims, providers submitted revised claims that resulted in net overpayments totaling $155,990. For the remaining three claims, providers agreed that they had submitted incorrect claims and said that they would submit revised claims. TriSpan made the incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect the errors in the provider claims.

RECOMMENDATIONS

We recommend that TriSpan:

- ensure identified overpayments have been recovered,
- follow up with the providers about the three claims that have not been revised,
- use the results of this audit in its provider education activities, and
- consider identifying and recovering any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2003.

TRISPAN'S COMMENTS

In its comments on our draft report, TriSpan agreed with our recommendations. The full text of TriSpan's comments is included as the Appendix.

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INTRODUCTION

BACKGROUND

Fiscal Intermediary Responsibilities

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer the Medicare Part A program. 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 Inpatient Services

Providers generate the claims for inpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (the PPS). In accordance with the PPS, fiscal intermediaries reimburse hospitals a predetermined amount depending on the illness and its classification under a diagnosis-related group (DRG). Inpatient stays that are extremely long or have extraordinarily high costs are eligible for an additional amount called an outlier payment.

The Medicare fiscal intermediary identifies outlier cases by comparing the estimated costs of a case to a DRG-specific fixed-loss threshold. Because hospitals cannot calculate the costs of cases individually, the fiscal intermediary uses the Medicare charges the hospital reports on its claim to estimate the cost of a case. Inaccurately reporting charges could lead to excessive outlier payments.

To process providers' inpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

In calendar year (CY) 2003, providers submitted approximately 13.5 million inpatient claims nationwide. Of these 13.5 million claims, only 3,128 claims resulted in payments of $200,000 or more (high-dollar payments). We considered such claims to be at high risk for overpayment.

TriSpan

TriSpan Health Services (TriSpan) is a Medicare Part A intermediary serving more than 1,800 Medicare providers in Mississippi, Louisiana, and Missouri. In CY 2003, TriSpan processed 401,754 inpatient claims that had payments of approximately $2.6 billion. Of these claims, TriSpan processed 38 claims that resulted in high-dollar payments.

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 high-dollar claims that

TriSpan processed were hospitals; thus, the term "provider," as used in the remainder of this report, refers to hospitals.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether TriSpans's high-dollar Medicare payments to Part A providers for inpatient services were appropriate.

Scope

We reviewed 38 high-dollar payments, totaling $12.9 million, that TriSpan processed during CY 2003. We limited our review of TriSpan's internal control structure to those controls applicable to the 38 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish a reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare Part A inpatient claims with high-dollar payments;
- reviewed available Common Working File claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our fieldwork;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly;
- reviewed itemized bills to determine whether the charges were appropriate; and
- coordinated our claim review with TriSpan.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

FINDINGS AND RECOMMENDATIONS

Eighteen of the 38 high-dollar payments that TriSpan made to providers were appropriate. However, TriSpan incorrectly paid providers for 20 claims. For 17 of the 20 claims, providers submitted revised claims that resulted in net overpayments totaling $155,990. For the remaining three claims, providers agreed that they had submitted incorrect claims and said that they would submit revised claims. TriSpan made the incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect the errors in the provider claims.

FEDERAL REQUIREMENTS

The Social Security Amendments of 1983 (Public Law 98-21) provided for the establishment of a PPS. In accordance with Medicare's PPS for inpatient acute care hospitals, reimbursement to hospitals for inpatient services furnished to beneficiaries is a predetermined amount, known as a DRG payment.

Section 1886(d)(5)(A) of the Social Security Act requires that Medicare pay hospitals an outlier payment in addition to the basic DRG amount to protect hospitals from incurring large financial losses due to unusually expensive cases. Furthermore, the "Hospital Manual," section 462, states: "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 HIGH-DOLLAR PAYMENTS

Twenty high-dollar claims (three of these have not been revised), totaling $155,990 in net overpayments, resulted in the following inappropriate payments:

- For two claims, the provider initially responded that the claims had been paid correctly. We asked the provider to review what we identified as excessive units or charges. After reviewing the items, the provider determined that it had overcharged the unit cost of one drug on one claim because the code for the drug was incorrectly programmed into its computer system. For both claims, the provider determined that the ventilation services were billed in error. This occurred because the computer system charged the service to the day following the day upon which the charge was incurred when the charge was entered into the system after midnight, resulting in excess hours on some days and underreported hours on other days. The provider's old computer system was replaced and the new system has the necessary information and edits. As a result, TriSpan paid the provider $466,610 when it should have paid $379,083, a net overpayment of $87,527.

- On one claim, a provider mistakenly charged pulse oximetry services separately rather than include them as a routine charge in the daily room rate. During a line-by-line

internal audit of the claims, the provider also found additional incorrect charges in several departments. As a result, TriSpan paid the provider $370,334 when it should have paid $361,263, an overpayment of $9,071.

- For five claims, the provider performed a DRG designation review and a detailed review that identified a DRG change for one claim and overcharges and undercharges for all five claims. The DRG error was caused by a misapplication of coding guidelines for principal diagnosis sequencing and procedure code assignment. The overcharges were related to: (1) separate charges for units of blood, (2) a lack of documentation to support the service, (3) incorrect accounting for infusion charges, (4) charges that were included in charges for another service, (5) charges that were not credited back to the account when drugs were returned to the pharmacy, and (6) services provided without a physician's order. The undercharges occurred because charges for care provided to the patients were not entered on the patient's account. As a result, TriSpan paid the provider $1,102,316 when it should have paid $1,099,074, a net overpayment of $3,242.

- For two claims, the provider performed a detailed review of codes for lab, pharmacy, and surgery charges of more than $200 and all recurring charges under $200. The review identified both overpayments and underpayments on each claim. Overcharges were found in the lab, pharmacy, radiology, and cardiology departments and undercharges were found in the lab, pharmacy, and emergency departments. As a result, TriSpan paid the provider $474,242 when it should have paid $445,526, an overpayment of $28,716.

- For three claims, the provider performed a detailed review that identified both overpayments and underpayments on each claim. The overcharges were related to: (1) a lack of nursing documentation in the medical record to support the charge, (2) drug charges that were entered into the system after an order was entered to discontinue the drug, (3) keying errors, (4) charges for drugs that were returned to the pharmacy but not credited to the account, (5) charges for a different patient, (6) duplicate billings, and (7) charges that were included in charges for another service. The undercharges were associated with care that was provided to patients but not charged to their accounts. As a result, TriSpan paid the provider $668,963 when it should have paid $666,634, a net overpayment of $2,329.

- For one claim, the provider performed a detailed review that identified both overpayments and underpayments. The overcharges were related to a lack of supporting documentation and errors in the number of units billed. The undercharges were associated with charges that were credited to an account rather than billed. As a result, TriSpan paid the provider $231,935 when it should have paid $211,780, an overpayment of $20,155.

- For three claims, the provider performed a detailed review that identified charge corrections. Based on the information provided, we could not determine the reason for the charge corrections. As a result, TriSpan paid the provider $736,287 when it should have paid $731,337, a net overpayment of $4,950.

- For two claims, the provider performed a detailed review of all charges other than the pharmacy charges. Because of the high number of pharmacy charges, the provider sampled the charges. The review identified both overpayments and underpayments for the claims. Based on the information provided, we could not determine the reason for the charge corrections. The provider had not submitted corrected claims by the end of our audit.

- For one claim, the provider found that the claim was missing charges and credits and contained undocumented charges. Based on the information provided, we could not determine the reason for the charge corrections. The provider had not submitted a corrected claim by the end of our audit.

CAUSES OF INCORRECT PAYMENTS

The providers agreed that incorrect payments occurred on the claims and that a refund was due or has already been made. The providers attributed the incorrect claims to clerical errors or to programming errors in the billing systems that could not detect and prevent the incorrect billing of units of service. TriSpan made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect the errors in the provider claims. Medicare relied on providers to notify the intermediaries of excessive payments.

RECOMMENDATIONS

We recommend that TriSpan:

- ensure identified overpayments have been recovered,

- follow up with the providers about the three claims that have not been revised,

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

- consider identifying and recovering any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2003.

TRISPAN'S COMMENTS

In its comments on our draft report, TriSpan agreed with our recommendations. In response to the first recommendation, TriSpan said that overpayments had been recovered for 17 of the 20 claims. In response to the second recommendation, TriSpan said that the providers had submitted adjustments for the overpayments; however, due to a problem related to retrieval of archived claims, the adjustments had not been made. In response to the third recommendation, TriSpan said that it was planning to publish frequently asked questions on its Web site to help providers understand the impact of billing excessive units and the importance of billing correctly. TriSpan also said that it was planning to include the information in any applicable presentations or teleconferences that it holds for providers. In response to the fourth recommendation, Trispan's claims department will

coordinate efforts with the systems and medical review departments to identify and recover any unusual high-dollar Part A inpatient overpayments made after CY 2003.

The full text of TriSpan's comments is included as the Appendix.

APPENDIX

TRISPAN
HEALTH SERVICES, INC.
MEDICARE PART A INTERMEDIARY
A CMS Contracted Intermediary

www.trispan.com
P. O. Box 23046 • Jackson, MS • 39225-3046

February 29, 2008

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

Dear Mr. Sato:

This letter provides written comments from TriSpan Health Services, Inc. related to the Office of Inspector General (OIG) draft report number A-06-07-00083 entitled "Review of High-Dollar Payments for Medicare Part A Claims Processed by TriSpan Health Services for the Period January 1, 2003, Through December 31, 2003."

For calendar year (CY) 2003, TriSpan processed approximately 401,754 inpatient claims, 38 of which resulted in payments of $200,000 or more (high-dollar payments). The audit objective was to determine whether the high-dollar Medicare payments that TriSpan made to hospitals for inpatient services were appropriate. The OIG contacted the hospitals that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect and whether the hospitals agreed that refunds were appropriate.

Of the 38 high-dollar payments that TriSpan made for inpatient services for CY 2003, twenty of the payments were not appropriate.

- Providers submitted seventeen revised claims that resulted in net overpayments totaling $155,990.
- For the remaining three claims, providers agreed they had submitted incorrect claims and said they would submit revised claims.

TriSpan made the incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect the errors in the provider claims.

In the OIG draft report, there were four recommendations:

1) ensure identified overpayments have been recovered,
2) follow up with the providers about the three claims that have not been revised,

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

3) use the results of this audit in its provider education activities, and
4) consider identifying and recovering any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2003.

In response to the first recommendation:

- TriSpan ensured overpayments were recovered on seventeen of the twenty claims.

In response to the second recommendation:

- Two of the payments were refunded by the provider by check without submitting the claim adjustments. TriSpan contacted the provider and requested they file revised claims. The provider submitted the adjustments; however, as conveyed to Matt Moore in several phone conversations, due to a System Maintainer problem related to retrieval of archived claims, the adjustments are still pending finalization.
- For the third payment, the provider submitted the adjustment; however, as conveyed to Matt Moore in several phone conversations, due to a System Maintainer problem related to retrieval of archived claims, the adjustment is still pending finalization.

In response to the third recommendation:

- TriSpan plans to publish Frequently Asked Question(s) on our Web site to help our providers understand the impact of billing excessive units and to know the importance of billing correctly.
- TriSpan will also include this information in any applicable presentations or teleconferences held for our provider community during the fiscal year.

In response to the fourth recommendation:

- TriSpan's Claims Department will coordinate with the Systems Department and the Medical Review Department to identify and recover any unusual high-dollar Part A inpatient claim payments after CY 2003.

If you have any questions or comments regarding this letter, please feel free to call me at (601) 664-4505.

Sincerely,

Jennifer Sumrall
Manager, Medicare Claims, Customer Service, Outreach and Education
TriSpan Health Services, Inc.