November 30, 2009

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of High-Dollar Inpatient Claims Processed by Cahaba Government Benefit Administrators, LLC (Contractor No. 00010), for Calendar Years 2004 Through 2006 (A-04-08-00039)

Attached is an advance copy of our final report on high-dollar inpatient claims processed by Cahaba Government Benefit Administrators, LLC (Cahaba), for calendar years 2004 through 2006. We will issue this report to Cahaba within 5 business days. This audit was part of a nationwide review of payments for inpatient services of $200,000 or more (high-dollar payments).

During the audit period, Cahaba was the fiscal intermediary for Alabama as contractor No. 00010. Cahaba processed approximately 1 million inpatient claims during this period, 97 of which resulted in high-dollar payments.

Our objective was to determine whether high-dollar Medicare payments that Cahaba made to Alabama hospitals for inpatient services were appropriate.

Of the 97 high-dollar payments that Cahaba made to Alabama hospitals for inpatient services during calendar years 2004 through 2006, 49 were appropriate. The 48 remaining payments included overpayments totaling $1,503,244, which had not been repaid by the start of our audit.

Contrary to Federal guidance, hospitals reported excessive units of service and charges that resulted in inappropriate outlier or add-on payments, and hospitals failed to maintain documentation of all charges filed. Hospitals generally attributed the incorrect claims to data entry errors or insufficient documentation. Cahaba made these incorrect payments because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place to detect and prevent the overpayments. Additionally, Cahaba overpaid one claim because it used an incorrect wage index when determining the payment. Cahaba attributed this overpayment to a data entry error.

We recommend that Cahaba (1) recover the $1,503,244 in identified overpayments, (2) use the results of this audit in its provider education activities, and (3) consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.

In written comments on our draft report, Cahaba agreed with our recommendations. Cahaba stated that it would post the necessary adjustments to begin the collection effort and include information about what contributed to the overpayments in its provider outreach and education efforts. Cahaba also stated that it would wait for direction from the Centers for Medicare & Medicaid Services before implementing controls to identify and review all payments greater than $200,000 for inpatient services.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Peter J. Barbera, Regional Inspector General for Audit Services, Region IV, at (404) 562-7750 or through email at Peter.Barbera@oig.hhs.gov. Please refer to report number A-04-08-00039.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

Office of Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, GA 30303

December 7, 2009

Report Number: A-04-08-00039

Ms. Lynda Northcutt
President
Cahaba Government Benefit Administrators, LLC
300 Corporate Parkway
Birmingham, Alabama 35242

Dear Ms. Northcutt:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Inpatient Claims Processed by Cahaba Government Benefit Administrators, LLC (Contractor No. 00010), for Calendar Years 2004 Through 2006." 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Eric Bowen, Audit Manager, at (404) 562-7789 or through email at Eric.Bowen@oig.hhs.gov. Please refer to report number A-04-08-00039 in all correspondence.

Sincerely,

/Peter J. Barbera/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR INPATIENT CLAIMS PROCESSED BY CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC (CONTRACTOR NO. 00010), FOR CALENDAR YEARS 2004 THROUGH 2006

Daniel R. Levinson
Inspector General

December 2009
A-04-08-00039

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries to process and pay Medicare Part A claims submitted by hospitals. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

Section 1886(d) of the Act established the prospective payment system for inpatient hospital services. Under the prospective payment system, CMS pays hospital costs at predetermined rates for patient discharges based on the diagnosis-related group to which a beneficiary's stay is assigned. The "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 3, section 10.1, requires that hospitals submit claims on the appropriate forms for all provider billings, and chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

The diagnosis-related group payment is, with certain exceptions, payment in full to the hospital for all inpatient services. Section 1886(d)(5)(A)(ii) of the Act provides for an additional payment, known as an outlier payment, to hospitals for cases incurring extraordinarily high costs. Also, section 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides for an additional payment, known as an add-on payment, for blood clotting factor administered to hemophilia inpatients.

During calendar years 2004 through 2006, Cahaba Government Benefit Administrators, LLC (Cahaba), was the fiscal intermediary for Alabama as contractor No. 00010. Cahaba processed approximately 1 million inpatient claims during this period, 97 of which resulted in payments of $200,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that Cahaba made to Alabama hospitals for inpatient services were appropriate.

SUMMARY OF FINDINGS

Of the 97 high-dollar payments that Cahaba made to Alabama hospitals for inpatient services during calendar years 2004 through 2006, 49 were appropriate. The 48 remaining payments included overpayments totaling $1,503,244, which had not been repaid by the start of our audit.

Contrary to Federal guidance, hospitals reported excessive units of service and charges that resulted in inappropriate outlier or add-on payments, and hospitals failed to maintain documentation of all charges filed. Hospitals generally attributed the incorrect claims to data

entry errors or insufficient documentation. Cahaba made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments. Additionally, Cahaba overpaid one claim because it used an incorrect wage index when determining the payment. Cahaba attributed this overpayment to a data entry error.

RECOMMENDATIONS

We recommend that Cahaba:

- recover the $1,503,244 in identified overpayments,
- use the results of this audit in its provider education activities, and
- consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

In written comments on our draft report, Cahaba agreed with our recommendations. Cahaba stated that it would post the necessary adjustments to begin the collection effort and include information about what contributed to the overpayments in its provider outreach and education efforts. Cahaba also stated that it would wait for direction from CMS before implementing controls to identify and review all payments greater than $200,000 for inpatient services.

Cahaba's comments are included in their entirety as the Appendix.

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CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part A claims submitted by hospitals. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process hospitals' inpatient claims. The CWF can detect certain improper payments during prepayment validation.

In calendar years (CY) 2004 through 2006, fiscal intermediaries processed and paid approximately 40.6 million inpatient claims, 8,287 of which resulted in payments of $200,000 or more (high-dollar payments).

Claims for Inpatient Services

Section 1886(d) of the Act established the prospective payment system for inpatient hospital services. Under the prospective payment system, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay. The "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 3, section 10.1, requires that hospitals submit claims on the appropriate forms for all provider billings, and chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

Section 1886(d)(5)(A)(ii) of the Act provides for an additional Medicare payment, known as an outlier payment, to hospitals for cases incurring extraordinarily high costs.[1] The fiscal intermediary identifies outlier cases by comparing the estimated costs of a case with a DRG-specific fixed-loss threshold.[2] To estimate the costs of a case, the fiscal intermediary uses the Medicare charges that the hospital reports on its claim and the hospital-specific cost-to-charge ratio. Also, section 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides for an additional payment, known as an add-on payment, for blood clotting factor administered to hemophilia inpatients. Inaccurately reporting charges or units of service could lead to excessive outlier or add-on payments.

[1]Outlier payments occur when a hospital's charges for a particular Medicare beneficiary's inpatient stay substantially exceed the DRG payment.

[2]A DRG-specific fixed-loss threshold is a dollar amount by which the costs of a case must exceed payments to qualify for an outlier payment.

Cahaba Government Benefit Administrators, LLC

During our audit period (CYs 2004 through 2006), Cahaba Government Benefit Administrators, LLC (Cahaba), was the fiscal intermediary for Alabama as contractor No. 00010. Cahaba processed approximately 1 million inpatient claims during this period, 97 of which resulted in payments of $200,000 or more (high-dollar payments).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that Cahaba made to Alabama hospitals for inpatient services were appropriate.

Scope

We reviewed the 97 high-dollar payments, which totaled approximately $26.2 million, for inpatient claims that Cahaba processed during CYs 2004 through 2006. We limited our review of Cahaba's internal controls to those applicable to the 97 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 reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History file, but we did not assess the completeness of the file.

We conducted our fieldwork from November 2007 through October 2008. Our fieldwork included contacting Cahaba, located in Birmingham, Alabama, and the hospitals that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- used CMS's National Claims History file to identify inpatient claims with high-dollar Medicare payments;

- reviewed available CWF claim histories for the 97 high-dollar payments to determine whether the claims had been canceled and superseded by revised claims and whether payments remained outstanding at the time of our fieldwork; and

- 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.

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 objective.

FINDINGS AND RECOMMENDATIONS

Of the 97 high-dollar payments that Cahaba made to Alabama hospitals for inpatient services during CYs 2004 through 2006, 49 were appropriate. The 48 remaining payments included overpayments totaling $1,503,244, which had not been repaid by the start of our audit.

Contrary to Federal guidance, hospitals reported excessive units of service and charges that resulted in inappropriate outlier or add-on payments, and hospitals failed to maintain documentation of all charges filed. Hospitals generally attributed the incorrect claims to data entry errors or insufficient documentation. Cahaba made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments. Additionally, Cahaba overpaid one claim because it used an incorrect wage index when determining the payment. Cahaba attributed this overpayment to a data entry error.

FEDERAL REQUIREMENTS

Section 1815(a) of the Act prohibits Medicare payment for claims not supported by sufficient documentation. The "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 3, section 10.1, requires that hospitals submit claims on the appropriate forms for all provider billings, and chapter 1, section 80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

Section 1886(d)(5)(A)(ii) of the Act provides for Medicare outlier payments to hospitals, in addition to prospective payments, for cases incurring extraordinarily high costs. CMS provides for these additional payments, as specified in 42 CFR § 412.80, to hospitals for covered inpatient hospital services furnished to a Medicare beneficiary if the hospital's charges, as adjusted by the hospital-specific cost-to-charge ratio, exceed the DRG payment for the case.

Section 6011 of the Omnibus Budget Reconciliation Act of 1989 (P.L. No. 101-239) provides that hospitals under the prospective payment system receive an additional payment for the cost of administering blood clotting factor to Medicare beneficiaries with hemophilia during an inpatient stay.[3] The payment is based on a predetermined price per unit of clotting factor multiplied by the number of units provided. During our audit period, the "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 3, section 20.7.3, required that 100 international units (IU) of

[3]Section 6011(d) was amended by section 13505 of the Omnibus Budget Reconciliation Act of 1993 (P.L. No. 103-66) and section 4452 of the Balanced Budget Act of 1997 (P.L. No. 105-33) effective for discharges occurring on or after June 19, 1990, and before October 1, 1994, and for discharges occurring on or after October 1, 1997, respectively.

clotting factor be reported as 1 billing unit. Accordingly, when billing for clotting factor, hospitals were required to divide the number of IUs administered by 100.[4]

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Cahaba made 48 overpayments totaling $1,503,244, which hospitals had not refunded by the start of our audit. Generally, hospitals received these overpayments by reporting excessive units of service and excessive charges that resulted in inappropriate outlier or add-on payments and by failing to maintain documentation for all charges billed. Additionally, Cahaba overpaid one claim because it used an incorrect wage index when determining the payment. The following examples illustrate these high-dollar payments:

- A hospital submitted a claim for 7,980 units of service for blood factor instead of the 79.8 units that should have been claimed. The hospital's manual billing process did not divide the blood factor IUs by 100, as Medicare required at the time. As a result, Cahaba overpaid the hospital $511,799.

- Five hospitals submitted 23 claims that lacked supporting documentation to justify the charges billed. As a result, Cahaba overpaid the hospitals $186,914.

- A hospital submitted two claims for 33,205 units of service instead of the 32,609 units that should have been claimed. As a result, Cahaba overpaid the hospital $10,747.

- A hospital listed its wage index as 0.9175 and submitted a claim for $13,268. The hospital should have been reimbursed $5,116. However, Cahaba incorrectly used a wage index of 96.0 and paid the hospital $352,191. As a result, Cahaba overpaid the hospital $347,075.

CAUSES OF OVERPAYMENTS

Hospitals generally attributed the incorrect claims to data entry errors or insufficient documentation. Additionally, Cahaba overpaid one claim because a data entry error resulted in the use of an incorrect wage index. Cahaba made the other incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to detect and prevent the overpayments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Medicare Summary Notice" and disclose any overpayments.[5]

[4]Effective July 14, 2006, CMS Transmittal 903, Change Request 4229, instructed fiscal intermediaries to instruct providers to no longer divide the number of IUs administered by 100 when billing for clotting factor.

[5]The fiscal intermediary sends a "Medicare Summary Notice" to the beneficiary after the hospital files a claim for Part A service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

RECOMMENDATIONS

We recommend that Cahaba:

- recover the $1,503,244 in identified overpayments,
- use the results of this audit in its provider education activities, and
- consider implementing controls to identify and review all payments greater than $200,000 for inpatient services.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

In written comments on our draft report, Cahaba agreed with our recommendations. Cahaba stated that it would post the necessary adjustments to begin the collection effort and include information about what contributed to the overpayments in its provider outreach and education efforts. Cahaba also stated that it would wait for direction from CMS before implementing controls to identify and review all payments greater than $200,000 for inpatient services.

Cahaba's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

CAHABA
GOVERNMENT
BENEFIT
ADMINISTRATORS,LLC

Sherrie D. LeMier
President and Chief Operating Officer
Cahaba Government Benefit Administrators® LLC

August 19, 2009

Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Attention: Peter J. Barbera
Regional Inspector General for Audit Services
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

RE: Report Number: A-04-08-0039 Review of High-Dollar Inpatient Claims Processed by Cahaba Government Benefits Administrator Fiscal Intermediary No. 00010 for the Period January 1, 2004, Through December 31, 2006.

Dear Mr. Bowen,

We are in receipt of the captioned draft report. We agree with the report and recommendations. We will begin reviewing the claims and post the necessary adjustments to begin the respective collection effort. Cahaba will include information about what contributed to the overpayments in our Provider Outreach and Education. We will await direction from the Centers for Medicare and Medicaid Services before we act on the recommendation to implement controls to identify and review all payments greater than $200,000 for inpatient services.

If you should have any questions regarding this report, please contact Molly Echols, Manager Risk and Compliance at (205) 220-1587 or via email at Mechols@cahabagba.com.

Sincerely,

Sherrie D. LeMier
President and Chief Operating Officer,
Cahaba Government Benefit Administrators®, LLC

CC: Brandon Ward, Vice President, Cahaba GBA Operations
David Brown, Director, Cahaba GBA Administration
Jim Hill, A/B Claims Operation Divisional Manager
Fred Schlich, Manager of Cahaba GBA Contracts/Subcontracts