DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 0429
Kansas City, Missouri 64106

November 8, 2010

Report Number: A-07-10-04164

Mr. Michael Hamerlik
President and Chief Operating Officer
Noridian Administrative Services, LLC
900 42nd Street South
Fargo, ND 58103

Dear Mr. Hamerlik:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Selected Payments for Inpatient Services Processed by Noridian Administrative Services, LLC, for Calendar Years 2006 Through 2008*. 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 at (816) 426-3591, or contact Debra Keasling, Audit Manager, at (816) 426-3213 or through email at Debra.Keasling@oig.hhs.gov. Please refer to report number A-07-10-04164 in all correspondence.

Sincerely,

/Patrick J. Cogley/
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, MO 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SELECTED PAYMENTS FOR INPATIENT SERVICES PROCESSED BY NORIDIAN ADMINISTRATIVE SERVICES, LLC, FOR CALENDAR YEARS 2006 THROUGH 2008

Daniel R. Levinson
Inspector General

November 2010
A-07-10-04164

Office of Inspector General

http://oig.hhs.gov

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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.

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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 Medicare contractors to process and pay Medicare claims submitted by hospitals. The Medicare contractors 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, knows as an outlier payment, to hospitals for cases incurring extraordinarily high costs.

During calendar years (CY) 2006 through 2008, Noridian Administrative Services, LLC (Noridian), was the Medicare contractor for Jurisdiction 3 in six States. For Jurisdiction 3, Noridian processed 121 Medicare Part A inpatient claims during this period in which payments exceeded charges by at least $25,000. We limited our review to 68 of the 121 inpatient claims submitted by hospitals that we are concurrently reviewing in an audit of outpatient services (A-07-10-04163).

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges that Noridian made to hospitals for hospital inpatient services were correct.

SUMMARY OF FINDINGS

Of the 68 selected Medicare payments that exceeded charges that Noridian made for inpatient services for CYs 2006 through 2008, 45 were correct. The 23 remaining payments were incorrect and included overpayments totaling $714,716, which the hospitals had not refunded by the beginning of our audit.

Contrary to Federal guidance, hospitals inaccurately billed Medicare by reporting incorrect procedure codes and by submitting claims with other inaccuracies, the excessive charges for which resulted in incorrect payments. Hospitals attributed most of the incorrect claims to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units

of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the incorrect payments.

RECOMMENDATIONS

We recommend that Noridian:

- recover the $714,716 in net overpayments and

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

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Noridian's comments are included in their entirety as the Appendix.

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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 Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted by hospital inpatient departments.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process hospitals' inpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Inpatient Services

Section 1886(d) of the Act established the prospective payment system (PPS) for inpatient hospital services. Under the PPS, 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.[2] The Medicare contractor identifies outlier cases by comparing the estimated costs of a case with a DRG-specific fixed-loss threshold.[3] To estimate the costs of a case, the Medicare contractor uses

[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

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

[3] 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.

the Medicare charges that the hospital reports on its claim and the hospital-specific cost-to-charge ratio. Inaccurately reporting charges can lead to excessive outlier payments.

Noridian Administrative Services Limited Liability Corporation

During calendar years (CY) 2006 through 2008, Noridian Administrative Services, LLC (Noridian), was the Medicare contractor[4] for Jurisdiction 3 in six States: Arizona, Montana, North Dakota, South Dakota, Utah, and Wyoming. For Jurisdiction 3, Noridian processed 121 Medicare Part A inpatient claims during this period in which payments exceeded charges by at least $25,000.

OBJECTIVE, SCOPE AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges that Noridian made to hospitals for hospital inpatient services were correct.

Scope

We reviewed 68 of the 121 inpatient claims, processed and paid by Noridian during CYs 2006 through 2008, in which payments exceeded charges by at least $25,000. We simultaneously performed a separate audit of hospital outpatient claims processed by Noridian. For the purpose of this inpatient audit, we limited our scope to inpatient claims submitted by hospitals that we concurrently reviewed in the audit of outpatient services (A-07-10-04163).

We limited our review of Noridian's internal controls to those that were applicable to the 68 selected Medicare payments 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 the National Claims History file, but we did not assess the completeness of the file.

We conducted fieldwork from August 2009 through April 2010. Our fieldwork included contacting Noridian, located in Fargo, North Dakota, and contacting the 31 hospitals that received the selected Medicare payments.

Methodology

To accomplish our objective, we did the following:

- We reviewed applicable Federal laws, regulations, and guidance.

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[4] Pursuant to the MMA, Noridian became a MAC effective July 31, 2006, which was during our audit period.

- We used CMS's National Claims History file to identify inpatient claims for which the payments exceeded charges by at least $25,000.

- We contacted the 31 hospitals that received the selected Medicare payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect.

- We used CMS's National Claims History file to determine whether the relevant hospitals had appropriately corrected the incorrect claims.

- We discussed the results of our review with Noridian on September 30, 2010.

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 68 selected Medicare payments that exceeded charges that Noridian made for inpatient services for CYs 2006 through 2008, 45 were correct. The 23 remaining payments were incorrect and included overpayments totaling $714,716, which the hospitals had not refunded by the beginning of our audit.

Contrary to Federal guidance, hospitals inaccurately billed Medicare by reporting incorrect procedure codes and by submitting claims with other inaccuracies, the excessive charges for which resulted in incorrect payments. Hospitals attributed most of the incorrect claims to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Noridian made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the incorrect payments.

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.

INCORRECT MEDICARE PAYMENTS

Noridian made 23 overpayments totaling $714,716, which the hospitals had not refunded by the beginning of our audit. The overpayments involved hospital claims incorrectly submitted to Medicare as well as claims submitted with inaccurate data, including incorrect procedure codes and incorrect numbers of billing units of service.

The following examples illustrate the billing errors:

- One hospital billed Medicare directly for surgical procedures when it should have billed the facility where the patient was a long-term patient, resulting in a total overpayment of $73,786.

- One hospital billed a patient's acute respiratory failure as the principal diagnosis, when in fact this condition should have been billed as secondary to obstructive sleep apnea, resulting in a total overpayment of $66,997.

- One hospital billed for an excisional debridement[5] when it should have billed for a non-excisional debridement, resulting in a total overpayment of $26,189.

The hospitals attributed most of the incorrect claims to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors.

CAUSES OF INCORRECT MEDICARE PAYMENTS

Noridian made the incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on hospitals to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.[6]

RECOMMENDATIONS

We recommend that Noridian:

- recover the $714,716 in net overpayments and

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

[5] Excisional debridement is the surgical removal or cutting away of devitalized tissue.

[6] The Medicare contractor sends a *Medicare Summary Notice* to the beneficiary after the hospital files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

In written comments on our draft report, Noridian concurred with our recommendations and described corrective actions that it had taken or planned to take. Noridian's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: NORIDIAN ADMINISTRATIVE SERVICES, LLC, COMMENTS

NORIDIAN®
Administrative Services LLC

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November 3, 2010

Patrick J. Cogley
Office of Inspector General
Region VII
601 East 12th Street
Room 0429
Kansas City, MO 64106

RE: Report Number A-07-10-04164

Dear Mr. Cogley:

Thank you for the opportunity to respond to the draft report of the U.S. Department of Health & Human Services, Office of Inspector General (OIG) dated October 7, 2010, entitled, *Review of Selected Payments for Inpatient Services Processed by Noridian Administrative Services, LLC, for Calendar Years 2006 Through 2008*. We concur with the recommendations made by the OIG and our responses are below.

OIG Recommendations:

- *Recover the $714,716 in identified overpayments*

  NAS Response: NAS concurs with the recommendation that all overpayments identified ought to be collected. Noridian Administrative Services, LLC, (NAS) has reviewed all claims identified as overpayment by this report. NAS has already collected these overpayments either by provider refund check or adjustments made by the provider.

- *Use the results of this audit in its hospital education activities*

  NAS Response: NAS concurs with the OIG. The OIG will be proving NAS with a detailed listing of the audit findings. Upon receipt, NAS will assess the results and direct future hospital education and /or focused medical reviews as necessary to address these provider billing errors. Also, with the same information, NAS can determine if these billing errors can best be addressed by either system edits or if they are best identified through the manual review of medical records.

Please advise if additional information or further clarification is needed on any of our response.

Sincerely,

/s/ Paul O'Donnell

Paul O'Donnell
Vice President
Noridian Administrative Services, LLC