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MEDICARE

Millions of Dollars in Mistaken Payments Not Recovered

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Human Resources Division

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The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable Bob Packwood
Ranking Minority Member
Committee on Finance
United States Senate

Paying for about 25 percent of all hospital and physician services, Medicare is the nation's largest health care payer. In fiscal year 1991 over $100 billion will be spent on services provided to Medicare beneficiaries, and nearly 600 million Medicare claims will be processed. The significant dollars involved, combined with the large number of Medicare providers and beneficiaries, the complex, dynamic nature of Medicare payment policies, and the pressures to pay claims promptly, place great demands on Medicare claims-processing contractors. As a result, contractors need to employ effective internal controls to ensure the accuracy of program expenditures and the recovery of any funds mistakenly paid.

This report responds to your request that we review Medicare contractors' claims-processing activities. Specifically, we sought to identify (1) mistaken Medicare payments made to hospitals for inpatient services that resulted in refunds (credit balances) due Medicare, (2) the reasons for such payments, (3) hospital efforts to refund credit balances, and (4) Medicare contractor actions to recover amounts owed to the program.

To obtain this information, we reviewed a judgmental sample of credit balance cases at 17 hospitals in the District of Columbia, Illinois, Maryland, Virginia, and Washington. We also did work at the five intermediaries (insurance companies under contract with Medicare) that process Medicare claims for these hospitals.

Results in Brief

Hospitals serving Medicare beneficiaries owe the program millions of dollars in refunds. Each of the 17 hospitals we visited owed refunds to Medicare that collectively amounted to over $900,000. At several hospitals the amounts were substantial. For example, a Maryland hospital owed Medicare at least $327,000, and a Washington, D.C., hospital owed at least $138,000. The credit balances resulted primarily from Medicare

and another insurer mistakenly paying for the same inpatient service or Medicare paying twice for the same service.

The five Medicare intermediaries that service these hospitals lacked the necessary internal controls to ensure that credit balances were identified and promptly recovered. Intermediary officials told us that, due to resource constraints, credit balance recovery activities were a low priority.

As a result, many of the credit balances had remained outstanding for years, despite attempts by some hospitals to make repayment. At one intermediary over $600,000 in refund requests were not being processed, and many were over a year old. Three intermediaries lacked information on the dollar value or volume of such refunds. Further, in attempting to make refunds, some hospitals had not correctly completed the paperwork required by intermediaries, and the intermediaries had not followed up to ensure that problems were corrected and the amounts owed Medicare were recovered.

In March 1991, we discussed these matters and the need for corrective actions with Health Care Financing Administration (HCFA) officials. HCFA immediately acted to require the 48 nationwide intermediaries to (1) establish units responsible for identifying and recovering outstanding credit balances and (2) instruct hospitals to provide information on their outstanding credit balances and refund any amounts owed to Medicare. Preliminary information from this effort illustrates the magnitude of the problem. Partial returns from 11 intermediaries indicate that the hospitals they service owe refunds totaling $37 million.

HCFA's recent actions should help resolve many of the credit balance problems that we identified. However, additional efforts are needed to ensure that intermediaries identify and take actions to help prevent future credit balances.

Background

Authorized under title XVIII of the Social Security Act, Medicare is a health insurance program that covers about 33 million people aged 65 and over and certain individuals under 65 who are disabled. Medicare provides coverage under two parts. Part A—hospital insurance—covers inpatient hospital services, home health services, and various other institutional services. Part B—supplementary insurance—covers physician, outpatient hospital, and other health services, such as diagnostic tests. Most of the fiscal year 1991 expenditures, about $60 billion, will

be used to reimburse hospitals for inpatient services provided under part A.

Although Medicare provides health care coverage for most citizens over 65 years old, it is not always the primary insurer. The Congress has made Medicare the secondary payer when beneficiaries are covered by both Medicare and workers' compensation, certain employer-sponsored group health insurance plans, and automobile and other liability insurance plans. These are referred to as the Medicare Secondary Payer (MSP) provisions. Hospitals are responsible for obtaining data on beneficiaries' health insurance coverage in order to identify other insurers who should pay before Medicare. Hospitals receiving payments from both Medicare and a primary insurer must refund any amount due Medicare.

Medicare is administered by HCFA within the Department of Health and Human Services (HHS). HCFA establishes policies, develops operating guidelines, and ensures compliance with Medicare legislation. HCFA contracts with insurance companies, called intermediaries under part A, to process and pay claims for covered services. Intermediaries perform other administrative and operational tasks, such as reviewing claims, and are responsible for ensuring that any mistaken payments are identified and returned to the program.

To refund mistaken payments, most intermediaries require hospitals to submit (1) a cover sheet explaining the reason for the refund, (2) a copy of the original bill (credit), (3) a copy of the voucher showing the Medicare payment, and (4) an amended version of the bill clearly indicating the revisions needed to process the refund. This manual process is also used for adjustments to hospital bills where Medicare may owe additional amounts.

Objectives, Scope, and Methodology

The primary objectives of our review were to determine the extent of credit balances at 17 hospitals,[1] how each credit balance occurred, to whom refunds should be made, and hospitals' actions to refund and Medicare intermediaries' procedures to identify and recover mistaken payments. Our work was performed at 17 hospitals and 5 Medicare intermediaries (see app. I).

[1]We also obtained a credit balance report from Howard University Hospital in Washington, D.C., and selected 15 Medicare credit balances for review. However, our review was discontinued because the hospital's records were incomplete or could not be located. A hospital official advised us that the accounting system was being updated to maintain more current and accurate information.

Hospitals we visited maintained separate credit balance reports for each health insurer that was due a refund. We obtained a copy of each hospital's most recent report that identified Medicare patients and selected between 8 and 15 accounts for review. We selected 234 patient accounts totaling $2,968,439. Eliminating the cases where the credit balance was a result of an internal hospital accounting adjustment, we reviewed 196 cases totaling $1,654,161. For the 196 cases, we reviewed hospital admission and financial records to determine whether a credit balance existed and how it occurred, who was the primary payer for the services provided, and whether Medicare was due a refund.

We also selected 18 patient accounts from 5 hospital reports that contained information on credit balances due insurers other than Medicare. We wanted to determine whether other insurers' credit balance reports included accounts that Medicare had paid on and, if so, whether Medicare was due a refund.

For all the sample cases where Medicare was due a refund, at the intermediary we reviewed beneficiary payment histories to determine why the Medicare mistaken payment had occurred and what actions Medicare had taken to recover it. For cases where the hospital lacked the necessary information for us to determine the primary payer, we reviewed applicable MSP provisions and beneficiary information maintained by the intermediary.

In two cases, totaling $30,445, we could not resolve the credit balances. In one case, neither the hospital nor the intermediary had sufficient information to enable us to determine who should have been the primary payer. In the second case, hospital records showed that Medicare had made duplicate payments, but records at the contractor showed that Medicare had paid the claim only once.

We performed our work between May 1990 and May 1991 in accordance with generally accepted government auditing standards. Though indicative of possible problems at other hospitals, our results are not projectable to the universe of hospitals.

Significant Amounts Owed to Medicare

The 17 hospitals we visited owed refunds to Medicare caused primarily by either payments from more than one insurer or duplicate Medicare payments. Our review of 196 patient accounts showed that the hospitals had accumulated about $1.7 million in mistaken payments that should

be refunded to Medicare, other federal and private insurers, and Medicare beneficiaries. As shown in table 1, we found that over $900,000, or 55 percent of the mistaken payments, was due Medicare.[2]

Table 1: Credit Balances at the 17 Hospitals

Payers to be refunded	Number of cases	Amount	Percent of total mistaken payments
Medicare	88	$912,261	55.2
Medicaid/CHAMPUS[a]	12	121,149	7.3
Patients	13	7,353	0.5
Private/commercial insurers	81	582,953	35.2
Undetermined	2	30,445	1.8
Total	**196**	**$1,654,161**	**100.0**

[a]Civilian Health and Medical Program of the Uniformed Services.

Each of the 17 hospitals owed Medicare refunds ranging from about $1,300 to more than $327,400; 13 hospitals owed more than $15,000 (see app. II). On the average, the credit balances were about 20 months old, and two hospitals had refunds due Medicare dating back to 1986. We discussed the mistaken payments with the intermediaries, and as of April 1, 1991, they had recovered $322,395.

At the hospitals we visited, additional payments may be due Medicare. Only three hospitals were able to provide a complete list of all credit balances due Medicare. The other 14 generated credit balance reports based on the primary payer or the insurer or patient who made the most recent payment. When Medicare was not the primary payer or the most recent payer of record, reports of other insurers had to be searched to determine if any additional refunds were due Medicare. Our review of 18 patient credit balances contained on other insurers' reports showed that 4, totaling about $34,000, should be refunded to Medicare. These cases were not identified on the Medicare credit balance reports provided by the hospitals.

Reasons for Medicare Credit Balances

The 88 Medicare credit balances occurred for a number of reasons. In 56 (64 percent) of the cases reviewed, both Medicare and another insurer paid for the same beneficiary services. In these cases, Medicare was later determined to be the secondary payer. In 23 cases (26 percent),

[2]Our work was directed at identifying Medicare credit balances. However, we informed Medicaid and CHAMPUS officials regarding the overpayments due to these programs.

Medicare made more than one payment for the same patient stay. For example, on September 25, 1990, Medicare paid $11,826.42 for a beneficiary's 13-day hospital stay; a week later the hospital submitted an adjusted bill, but rather than adjusting the bill, Medicare paid the hospital again. For another beneficiary, Medicare made one payment of $16,366.33 and, when the hospital submitted an adjusted bill, a second payment of $17,444.18. The other nine cases (11 percent) occurred primarily when hospitals overbilled Medicare for beneficiary services or were paid for services that were later denied.

Credit Balances Not Always Recovered From Hospitals

Our review showed that hospitals made some attempts to refund credit balances but, for one reason or another, had not succeeded. When submitting paperwork to refund credit balances, hospitals must revise their original Medicare claim. In several cases, hospitals provided information needed to initiate a refund that was incorrect, according to intermediary officials. For example, minor changes, such as reversing the order of payer to show that Medicare was secondary, were not properly completed.

Intermediary officials said that incorrect refund forms were returned to the hospitals for correction. At the time of our work, HCFA did not require the intermediaries to track the refund requests that they rejected for errors or data omissions and returned to the hospitals for revision. As a result, there was no system to ensure that the hospitals resubmitted the refund paperwork and that Medicare recovered the funds.

Because of the paperwork involved to make refunds to Medicare and the lack of resources, most hospital officials said they generally give low priority to refunding payments and usually make one attempt to refund monies owed to Medicare. At an Illinois hospital we found evidence of attempted refunds for 14 cases totaling $63,296. Two of these mistaken payments occurred in 1986. However, the intermediary had no information on these attempted refunds.

Some hospital officials said that they wait for the intermediary to identify and seek recovery of any amounts owed. We found one hospital that retains specific beneficiary information (name, dates of service, amount

of credit balance due Medicare) for only 90 days.[3] After that, beneficiary information is transferred to microfiche, and amounts due Medicare are moved into a single holding account for 12 months. A hospital official said that the intermediary was notified that a refund should be processed. However, at the intermediary we found no evidence that the hospital was notifying Medicare of credit balances.[4]

Intermediaries Need to Take Actions to Identify and Recover Medicare Credit Balances

At the five intermediaries we reviewed, little was being done to identify Medicare credit balances and ensure that refunds were promptly recovered. None of the intermediaries had a specific unit designated to recover credit balances and, even when informed of amounts owed to Medicare, none had the necessary internal controls to assure that recoveries occurred.

Intermediary auditors are required to review credit balances, but the effort was not given high priority. MSP audits focus primarily on reviewing hospital admission policies to ensure that insurance information is obtained from Medicare beneficiaries. In addition, MSP auditors are required to review a sample of hospital credit balances to determine if Medicare was appropriately billed as the primary payer and, if incorrectly billed, ensure that Medicare credit balances are recovered. At the five intermediaries we reviewed, most MSP auditors were not reviewing Medicare credit balances.

Intermediary cost report auditors are also required to review credit balances. However, HCFA and intermediary officials stated that the credit balance review is given low priority because of the relatively small overall financial effect on hospital costs.[5] Further, because of the time needed to schedule and conduct cost report audits, 2 years may pass before an intermediary completes its review of a hospital's cost report. Thus, relying on these audits would allow Medicare credit balances to remain outstanding for long periods.

[3]Our review of this hospital's credit balance report showed that about $17,400 was owed Medicare during a 3-month period in 1990.

[4]We discussed this matter with the HHS Office of Inspector General, which is now reviewing this hospital's credit balance procedures.

[5]Hospital cost reports identify patient costs covered under the Medicare prospective payment system, as well as reimbursements for capital and medical education costs, and certain other hospital costs exempt from prospective payments.

In addition to limited audit coverage, some intermediaries did not inventory hospital-submitted adjustments that included refunds due Medicare. For example, as of February 1991, the Maryland intermediary had 7,600 unprocessed hospital requests for adjustments to previous bills. These requests were filed in folders containing the hospital's name, but the intermediary did not know how many were Medicare credit balances that the hospitals were attempting to refund. Our limited sample of 14 hospitals' submitted adjustments disclosed that the hospitals had requested the intermediary to process 414 refunds, totaling about $620,000. Many of the requests were over a year old. Intermediary officials stated that as of July 17, 1991, the backlog had been reduced to about 4,500.

Two other intermediaries we visited also had credit balance adjustment backlogs, but were unable to provide us with the dollar amount of the pending adjustments. Further, even when credit balances were identified, the lack of resources prevented recovery. At the Virginia intermediary and one Illinois intermediary, a potential $3.7 million in Medicare refunds had not been recovered. Intermediary officials reported that additional resources were needed to process these adjustments.

Recent HCFA Actions Should Help Recovery of Credit Balances

Before April 1991 HCFA provided little guidance to intermediaries on identifying and recovering Medicare credit balances and was unaware that hospitals were encountering problems when attempting to refund amounts owed Medicare. Since HCFA did not require hospitals to report credit balances, neither HCFA nor the intermediaries knew the amount of credit balances owed to Medicare by the more than 6,000 participating hospitals.

In March 1991 we informed HCFA officials of our preliminary findings regarding the outstanding credit balances at the 17 hospitals and the problems the intermediaries had in identifying and recovering balances. In addition, we proposed solutions to help resolve the identified problems. HCFA officials agreed that these matters needed immediate attention and, based on our suggestions, directed intermediaries to take a number of actions that should help identify and recover Medicare credit balances.

Intermediaries have been instructed to give a specific unit responsibility for resolving credit balances and report to HCFA regional offices by October 31, 1991, the total credit balances recovered so that HCFA can assess the results of the recovery effort. A HCFA official advised us that

preliminary data show that about $37 million is due to be refunded to Medicare at 11 intermediaries. In addition, within a year HCFA hopes to have in place a system that will allow hospitals and intermediaries to process credit balance adjustments electronically.

Also, in July 1991, all hospitals participating in the Medicare program began submitting to intermediaries quarterly reports indicating whether they had Medicare credit balances and, as appropriate, refunding any amounts owed. The reports included the name of the Medicare beneficiary, the beneficiary's hospital admission and discharge dates, the amount owed Medicare, and the reason for the credit balance (e.g., duplicate Medicare payment).

Although a number of hospitals submitted the reports, a HCFA official advised us that two provider representatives believed that imposition of the reporting requirements violated the Paperwork Reduction Act.[6] According to the HCFA official, the Office of Management and Budget (OMB) agreed and informed HCFA that it must justify the need for the reporting requirement, including obtaining OMB approval of any forms used to collect credit balance information. The HCFA official stated that the reporting requirements were suspended in August 1991. However, on September 27, 1991, this official advised us that HCFA will file a formal request seeking OMB approval to reinstitute the reporting requirement.

Conclusions

Recent HCFA actions, if appropriately implemented, should help intermediaries identify and recover hospital credit balances and help hospitals make timely refunds to Medicare. However, it is also important that intermediaries identify the causes of mistaken payments so that appropriate actions can be taken to prevent them from recurring. A recent HCFA reporting requirement that would have provided information on the reasons for mistaken payments has been suspended. However, HCFA plans to seek OMB approval to reinstitute quarterly reporting, which should provide data beneficial to Medicare intermediaries.

[6]The Paperwork Reduction Act of 1980 (P.L. 96-511) establishes a federal policy of ensuring that paperwork requirements are not imposed unless the practical value of the information to be collected is worth the burden imposed by the requirement. OMB is responsible for implementing this policy.

Recommendations

We recommend that the Secretary of HHS take the necessary steps to assure that HCFA

- monitors intermediaries' compliance with recent credit balance instructions and
- requires intermediaries to (1) identify the causes of Medicare credit balances and, where appropriate, initiate corrective actions and (2) assure that hospitals identify and make accurate refunds of all amounts owed to Medicare.

Our preliminary findings and suggestions for recovering outstanding hospital credit balances were outlined in a March 12, 1991, letter to HCFA's Director of Financial Operations. As noted above, HCFA initiated a number of corrective actions. Although we did not obtain written HCFA comments on this report, on July 18, 1991, we discussed it with HCFA officials, who agreed that our recommendations for further HCFA actions could help improve credit balance recovery activities.

Copies of this report are being sent to the Secretary of HHS; the Administrator of HCFA; interested congressional committees and subcommittees; the Director, OMB; and other interested parties. Copies will also be made available to others on request.

Please call me on (202) 275-5451 if you or your staffs have any questions concerning this report. Other major contributors are listed in appendix III.

Janet L. Shikles

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Director, Health Financing
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Contents

Abbreviations

CHAMPUS	Civilian Health and Medical Program of the Uniformed Services
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
MSP	Medicare Secondary Payer
OMB	Office of Management and Budget

Hospitals and Intermediaries Reviewed by GAO

Hospital	Intermediary
Alexian Brothers, Elk Grove Village, Ill.	Aetna, Ill.
Belmont Community, Chicago, Ill.	Aetna, Ill.
Highland Park, Highland Park, Ill.	BCBS,[a] Ill.
Northwestern Memorial, Chicago, Ill.	BCBS, Ill.
Rush Presbyterian-St. Luke, Chicago, Ill.	BCBS, Ill.
Fairfax, Fairfax, Va.	BCBS, Va.
Providence, Seattle, Wash.	BCBS, Wash.
Sacred Heart, Spokane, Wash.	BCBS, Wash.
Valley Medical, Renton, Wash.	BCBS, Wash.
Georgetown University, Washington, D.C.	BCBS, Md.
George Washington University, Washington, D.C.	BCBS, Md.
Providence, Washington, D.C.	BCBS, Md.
Washington Hospital Center, Washington, D.C.	BCBS, Md.
Johns Hopkins, Baltimore, Md.	BCBS, Md.
Greater Baltimore, Baltimore, Md.	BCBS, Md.
Union Memorial, Baltimore, Md.	BCBS, Md.
University of Maryland, Baltimore, Md.	BCBS, Md.

[a]BCBS = Blue Cross and Blue Shield.

Medicare Credit Balance Summary

Hospital	Medicare total credit balance	GAO sample	Amount due Medicare	Amount due Medicaid/ CHAMPUS	Amount due patient	Amount due other insurer	Undetermined
Northwestern Memorial	$593,622	$45,428	$30,913	$0	$546	$13,970	$0
Highland Park	72,888	61,516	12,434	0	287	48,795	0
Belmont Community	13,180	11,144	1,268	0	(723)	10,599	0
Alexian Brothers	212,935	53,447	63,296	0	(51)	(9,798)	0
Rush Presbyterian-St. Luke	580,493	56,028	18,784	0	0	37,244	0
Fairfax	239,092	65,049	27,010	0	0	38,040	0
Providence (Seattle)	272,352	67,828	51,899	0	0	15,929	0
Sacred Heart	239,469	43,206	25,817	8,267	1,323	7,799	0
Valley Medical	215,990	39,235	30,491	0	520	8,223	0
Georgetown University	63,408	35,158	17,410	0	0	17,748	0
Providence (D.C.)	84,280	41,331	8,875	592	0	31,864	0
Washington Hospital Center	1,217,054	358,163	137,736	0	1,152	219,275	0
George Washington University	327,239	101,419	41,924	0	1,632	57,862	0
Union Memorial	445,281	37,642	15,581	549	543	10,463	10,506
University of Maryland	309,053	110,706	58,358	9,570	1,522	41,256	0
Greater Baltimore	80,071	14,640	9,329	0	10	5,301	0
Johns Hopkins	707,184	347,350	327,411	0	0	0	19,939
Subtotal	**$5,673,591**	**$1,489,289**	**$878,535**	**$18,978**	**$6,761**	**$554,570**	**$30,445**
Sample of non-Medicare credit balance reports[a]							
Fairfax	$176,083	31,805	31,805	0	0	0	0
Georgetown	29,852	22,418	0	0	592	21,826	0
Valley Medical	16,863	4,595	1,921	0	0	2,674	0
Sacred Heart	136,809	72,123	0	68,240	0	3,883	0
Providence (Seattle)	124,914	33,931	0	33,931	0	0	0
Subtotal	**484,521**	**164,872**	**33,726**	**102,171**	**592**	**28,383**	**0**
Total	**$6,158,112**	**$1,654,161**	**$912,261**	**$121,149**	**$7,353**	**$582,953**	**$30,445**

[a]At these hospitals we reviewed other insurers' credit balance reports to determine if there were any refunds due Medicare.

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