



Audit Department

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Angela M. Darragh, CPA, CFE, CISA, Director

June 4, 2014

Mr. Don Burnette
Clark County Manager
500 South Grand Central Parkway, 6th Floor
Las Vegas, Nevada 89106

Dear Mr. Burnette:

Pursuant to Audit Department policy, we performed a Medicare Secondary Payer audit at University Medical Center of Southern Nevada. Our objective was to determine whether the procedures for identifying Medicare as a secondary payer provided reasonable assurance that eligible records were appropriately designated and billed correctly.

We selected the period of July through September 2013 and reviewed 80 records for the following:

- Documentation of Medicare secondary payer questionnaires
- Ensured compliance of Medicare secondary payer questionnaires with Medicare regulations
- Accurate identification of primary and secondary payers

We also performed testing for the dates of January 23 and 31, 2014, and reviewed the Medicare Credit Balance Report to ensure that overpayments from Medicare, if any, were refunded.

We identified two weaknesses in the Medicare billing process. We found instances in which Medicare secondary payer questionnaires were not completed as required and also instances in which the wrong payers were billed and a secondary payer was not billed.

We conducted the performance audit in accordance with generally accepted government auditing standards. Those standards required 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.

A draft report was provided to the Revenue Cycle Director, and her response is included.

Sincerely,

A handwritten signature in blue ink that reads "Angela M. Darragh".

Angela M. Darragh, CPA
Audit Director



AUDIT DEPARTMENT

Audit Report

University Medical Center of
Southern Nevada
Medicare Secondary Payer

June 2014

Angela M. Darragh, CPA, CISA, CFE
Audit Director

AUDIT COMMITTEE:

Commissioner Steve Sisolak

Commissioner Chris Giunchigliani

Commissioner Lawrence Weekly

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BACKGROUND As a Medicare provider, University Medical Center of Southern Nevada (UMC) is required to determine the appropriate primary and secondary payer for Medicare claims. Medicare represented approximately 19% of gross patient revenues for University Medical Center (UMC) for fiscal years 2012-2013.

OBJECTIVES, SCOPE, AND METHODOLOGY Our objective was to determine whether the procedures for Medicare billing provide reasonable assurance that UMC is in compliance with Medicare laws and regulations related to Medicare Secondary Payer. Our audit consisted of interviews with management and staff, examination of documentation, and performance of detailed tests and analyses.

In order to test the administration of the Medicare Secondary Payer questionnaire and 60 day repayment compliance, we selected a testing period of July through September 2013 and reviewed a sample set of 80 records. We also performed observations of Wellness Center and Lied Adult Clinic staff as they completed Medicare Secondary Payer questionnaires. Additionally, we reviewed the Medicare Credit Balance Reports for the dates of January 23 and January 31, 2014. This testing was completed to ensure the following:

- The Medicare Secondary Payer questionnaire was complete, consistently administered, and updated every 60 days.
- The appropriate primary payer was identified. Improper payments from Medicare were refunded within the 60 day requirement.
- If applicable, other insurance coverage was identified and billed.

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.

RESULTS IN BRIEF We identified two weaknesses in the Medicare billing process. We found instances in which Medicare secondary payer questionnaires were not completed as required and also instances in which Medicare was not billed as a secondary payer and should have been.

DETAILED RESULTS

Medicare Secondary Payer Questionnaires Not Completed (High) The Medicare secondary payer (MSP) questionnaire is required to be used to determine the primary and secondary payer when Medicare services are rendered. During our testing of patient records where Medicare was either the primary or secondary payer, we found that the Medicare secondary payer questionnaire was not fully completed by the Admit/Discharge Representatives in 32 of 80 cases (40%). Incomplete secondary payer questionnaires put UMC at risk for incorrectly billing Medicare as primary and submitting a false claim. Under the False Claims Act (FCA), a provider can be assessed a civil penalty of between \$5,500 and \$11,000 for each false claim, in addition to three times the amount of the damages sustained by the government as a result of the false claim.

Recommendation

1. Provide training to all Admit/Discharge Representatives on properly completing the MSP questionnaires as required by the Centers for Medicare and Medicaid Services.
2. Monitor staff completion of MSP forms and provide additional training or other corrective action when forms are not completed properly.

Medicare Billing Errors (High) During our review of 80 patient records where Medicare was either the primary or secondary payer, we found the following billing errors:

- In 3 out of 40 records (8%), Medicare should have been billed as a secondary payer, but only the primary payer was billed. When Medicare is not billed as the secondary payer, when allowable, it can lead to a loss of revenue.
- In 2 out of 40 records (5%) the insurance carrier identified for billing was incorrect, resulting in incorrect billing. Specifically, for one account, Medicare was billed instead of Veterans Affairs. In another account, Medicare was incorrectly billed

as the secondary insurer, when Medicare should have been billed as the primary insurer.

Incorrectly billing Medicare can violate the False Claims Act. Under the False Claims Act (FCA), a provider can be assessed a civil penalty of between \$5,500 and \$11,000 for each false claim, in addition to three times the amount of the damages sustained by the government as a result of the false claim.

Recommendation

1. Conduct and document Medicare billing training to ensure that the proper primary and secondary insurance carriers are correctly identified, entered and billed.
2. Implement self-monitoring procedures to ensure accounts are billed correctly.

MANAGEMENT RESPONSE

INTEROFFICE MEMORANDUM

TO: ANGELA DARRAGH, DIRECTOR, CLARK COUNTY, AUDIT DEPARTMENT
FROM: VIRGINIA CARR, DIRECTOR, REVENUE CYCLE|UMC
SUBJECT: MANAGEMENT RESPONSE TO MSP AUDIT
DATE: MAY 29, 2014

We respectfully offer the following in response to the Clark County Audit Department's Medicare Secondary Payer Audit.

Initial finding: Incomplete Medicare Secondary Payer questionnaires.

Concur: It was identified that the new system is unable to "hard stop" registration for incompleteness of the questionnaire the following steps are currently in place and resolved.

- A daily audit is now in place for all Medicare registrations to ensure that the questionnaire is complete. Accounts with incomplete questionnaires are reviewed with staff for improvement.
- Electronic eligibility system has been coded to automatically submit a verification request for any registrations with a patient age of 65 or older to identify possible coverage.
- An additional module is being implemented to identify and direct registrars to update at the point of registration with an estimated complete date of 9/1/2014.
- Ongoing education/training sessions occur for all registrars throughout the year to address work processes and requirements and the remainder of the calendar year will include MSP refresher coursework.

Initial Finding: Medicare billing errors.

- Accounts not billed to Medicare as a secondary payer.
- Insurance carrier billed was incorrect

Concur: Accounts in question were addressed and resolved.

- Three accounts were billed to the primary payer but balance was not transferred to the secondary payer (Medicare) with a total revenue risk of \$70.00. Education regarding transferring account balance occurred and accounts were submitted to Medicare for processing.
- Two accounts were billed under incorrect plan codes. These accounts were corrected and re-submitted. A daily report has been developed to identify sequencing of plan codes and is reviewed by billing staff for corrections.
- Additional training documentation will be completed by 7/31/14 for staff distribution and sign off.