

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF COSTS CLAIMED BY
ROCKY MOUNTAIN HEALTH
MAINTENANCE ORGANIZATION FOR
CALENDAR YEAR 1998**



**JANET REHNQUIST
INSPECTOR GENERAL**

**JANUARY 2002
A-07-00-02079**



Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

CIN: A-07-00-02079
January 8, 2002

Mr. Michael Weber
Chief Executive Officer
Rocky Mountain Health Maintenance Organization
P.O. Box 10600
Grand Junction, Colorado 81502-5500

Dear Mr. Weber:

This report provides the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) audit titled "Review of Costs Claimed by Rocky Mountain Health Maintenance Organization for Calendar Year 1998". The objective of the review was to evaluate the Medicare cost report for allowability of costs, and the claims processing system for potential payment of duplicate claims.

Generally, we found that costs claimed on the 1998 cost report were allowable and that Rocky Mountain Health Maintenance Organization (Rocky) was aggressive at recovering duplicate payments. We were able to determine that Rocky recovered \$1,951,092 due to duplicate payments providers received from both Rocky and the carrier. However, we were not able to trace the adjustment of the carrier's paid claim directly to claims paid by Rocky. Without this capability, it is not possible to determine that all appropriate adjustments are being made. We are recommending that Rocky strengthen its current claims processing system to provide a more efficient and effective method in recording the adjustments for duplicate payments.

INTRODUCTION

BACKGROUND

Rocky was incorporated in the State of Colorado in August 1974. It is a not-for-profit corporation which was designed and developed by physicians. Rocky began operations in Mesa County in 1974 and was the seventh HMO in the United States to become federally qualified. Physicians continue their active involvement in Rocky through participating in vital committee and Board functions.

Although the Rocky began operations in predominately rural areas in the State of Colorado, they had enrolled over 41 percent of the entire population of the original service area in and around Grand Junction during 1998. Rocky has been federally qualified since 1975 and has been a Medicare cost contractor since November 1977.

During calendar year 1998, Rocky offered a Medicare cost product statewide except for three counties. The Standard plan was offered in all counties except for the three counties excluded. The Plus plan was offered in the western region of the state, and the Gold plan is offered in the Front Range area. Outpatient prescription drugs are an added benefit under the Plus and Gold plans.

Rocky's total revenue for 1998 was \$183,502,247 and the net income, per the consolidated financial statements, was \$2,378,482. Revenue from Medicare and Medicaid contracts was \$85,670,003 or 47 percent of total revenues. For the period, Rocky was servicing approximately 96,125 members, including 65,333 commercial members, 16,985 Medicaid members, 11,814 Medicare members, and 1,993 members eligible for both Medicare and Medicaid.

OBJECTIVES, SCOPE AND METHODOLOGY

We performed our review in accordance with generally accepted government auditing standards. The objective of the review was to evaluate the Medicare cost report for allowability of costs, and the claims processing system for potential payment of duplicate claims.

To accomplish our objective, we obtained the Medicare cost report for calendar year 1998 from the Centers for Medicare and Medicaid Services¹(CMS). For calendar year 1998, Rocky reported \$25,105,196 in Medicare Part B reimbursable costs.

We reviewed support for selected expense accounts to determine the allowability and reasonableness of the amounts charged to the cost report. We used applicable Medicare laws, regulations, and guidelines to determine whether reported costs met Medicare requirements.

We reviewed Medicare claims data provided by Rocky and by the various Part B carriers. We matched the databases to determine which claims Rocky and the Part B carrier paid for Rocky Medicare enrollees. Because Rocky processed their Medicare claims internally, an emphasis was placed on the potential of duplicate payments.

Our internal control review included determining whether Rocky had appropriate procedures in place for:

- Effective and efficient claims processing,
- Continuously improved quality within the entity,

¹ On June 14, 2001, the Department of Health & Human Services announced that HCFA would be known as the Centers for Medicare and Medicaid Services.

We performed site work at Rocky’s headquarters in Grand Junction, Colorado, and at four providers in Grand Junction during.

FINDING AND RECOMMENDATION

Although Rocky was aggressive in identifying and adjusting duplicate payments, it was not possible to readily determine that all duplicate payments identified by Rocky were, in fact, adjusted.

Regarding duplicate payments, the HMO manual states:

Several entities may have jurisdiction over the processing and payment of Part B bills for your members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent upon you to establish a system to preclude or detect duplicate payments.

There are several reasons a claim may require an adjustment, including duplicate payments. The claim’s processing department makes most adjusting entries manually. Duplicate recoveries are entered into the system with the CPT code of “00019”. This code can represent five different adjustment reasons: claim never submitted to Rocky, charges prior to effective date, charges after termination date, charges not recovered, and lastly, a duplicate payment. We were not able to match these credits to the system because of the “made up” code. Thus, we were never able to identify exactly which procedure the carrier billed was a duplicate. We were only able to identify that the system did in fact recover duplicate payments from individual providers.

During calendar 1998, Rocky made adjustments of \$1.9 million for duplicate claims. This amount exceeded the amount of potential duplicate claims we were able to identify. As a result, we concluded that Rocky is aggressive in recovering duplicate claims. However, because of the inability to ensure that all adjustments were made, there may be additional dollars that were never adjusted.

RECOMMENDATION

We recommend that Rocky develop a system that would be capable of identifying the Rocky claim that was overpaid.

AUDITEE RESPONSE

Officials at Rocky generally agreed with our recommendation. They stated:

Since 1998, RMHMO has implemented a better system for processing claims which now allows better tracking of adjusted claims on a line item by line item basis. We also plan to explore the addition of reason codes that will better describe when an adjustment is made due to duplicate payment of services.

The complete text of Rocky's response is included at Appendix A.

Final determinations as to the actions taken on all matters reported will be made by the U.S. Department of Health and Human Services action official named below. We request that you respond to the action 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General, Office of Audit Services reports are made available to the public to the extent information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5). As such, within ten business days after the final report is issued, it will be posted on the world wide web at <http://www.hhs.gov/progorg/oig>.

To facilitate identification, please refer to Common Identification Number A-07-00-02079 in all correspondence relating to this report.

Sincerely,



James P. Aasmundstad
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. Mark Alark
CMS
Director, Division of Cost Plans
C3-14-00
7500 Security Boulevard
Baltimore, Maryland 21244-1850



December 10, 2001

VIA FACSIMILE (816) 426-3655
AND FIRST CLASS U.S. MAIL

James P. Aasmunstad, Regional
Inspector General for Audit Services
Office of Inspector General
Office of Audit Services
Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Re: CIN: A-07-00-02079

Dear Mr. Aasmunstad:

This letter is in response to the draft report of the results of the audit of Rocky Mountain Health Maintenance Organization, Inc.'s (RMHMO) 1998 Medicare costs that was conducted by the Office of Inspector General (OIG), Office of Audit Services (OAS.)

The single finding and recommendation of this report focuses on the identification of duplicate payments and claim adjustments in 1998. Since 1998, RMHMO has implemented a better system for processing claims which now allows better tracking of adjusted claims on a line item by line item basis. We also plan to explore the addition of reason codes that will better describe when an adjustment is made due to duplicate payment of services.

If you have any questions or need additional information, please contact George Narvaes, Director of Regulatory Affairs and Government Operations at 970-244-7802.

Sincerely,

A handwritten signature in black ink that reads "Michael J. Weber". The signature is written in a cursive style and includes a small "JMR" monogram at the end.

Michael J. Weber
Chief Executive Officer

MJW:kjg