



SEP 4 2008

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-07-06026

Ms. Gina Jenkins, Senior Director
Palmetto GBA – Railroad Medicare
2743 Perimeter Parkway
Building 200 – 4th Floor
Augusta, Georgia 30909

Dear Ms. Jenkins:

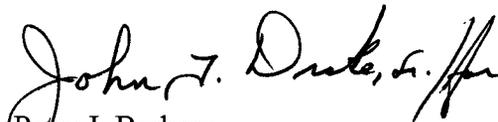
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled “Review of High-Dollar Payments for Medicare Part B Claims Processed by Palmetto GBA, Railroad Benefit Contractor #882, for the Period January 1, 2004, Through December 31, 2006.” 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.

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by P.L. No. 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR pt. 5). Accordingly, this report will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Mary Ann Moreno, Audit Manager, at (904) 232-2687 or through e-mail at Mary.Moreno@oig.hhs.gov. Please refer to report number A-04-07-06026 in all correspondence.

Sincerely,


Peter J. Barbera
Regional Inspector General
for Audit Services

Enclosure

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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
PAYMENTS FOR MEDICARE
PART B CLAIMS PROCESSED BY
PALMETTO GBA, RAILROAD
BENEFIT CONTRACTOR #882,
FOR THE PERIOD
JANUARY 1, 2004, THROUGH
DECEMBER 31, 2006**



Daniel R. Levinson
Inspector General

September 2008
A-04-07-06026

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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 Medicare program provides health insurance for people age 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 carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers). CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed.

Carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File to process Part B claims. These systems can detect certain improper payments during prepayment validation.

Palmetto GBA (Palmetto) is the Railroad Medicare Part B carrier for providers nationwide. During calendar years 2004–2006, Palmetto processed more than 37 million Railroad Part B claims, 145 of which resulted in payments of \$10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Palmetto's high-dollar Railroad Medicare payments to Part B providers were appropriate.

SUMMARY OF FINDING

Of the 145 high-dollar payments that Palmetto paid to providers, 137 were appropriate. Palmetto overpaid eight providers \$110,905 for the remaining claims.

The providers attributed the incorrect claims to clerical errors or insufficient documentation to support the units billed.

In addition, Palmetto made the overpayments because providers incorrectly submitted claims and the Medicare claim processing systems did not have sufficient edits in place during calendar years 2004–2006 to detect and prevent payments for these types of erroneous claims. However, in January 2007, Palmetto implemented CMS-required units-of-service edits referred to as "medically unlikely" edits to suspend potentially excessive Medicare payments for prepayment review.

RECOMMENDATION

We recommend that Palmetto recover the \$110,905 in overpayments.

PALMETTO GBA COMMENTS

In written comments on our draft report, Palmetto agreed to recover the \$110,905 in overpayments. The complete text of Palmetto's comments is included 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 age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B Carriers

Prior to October 1, 2005, section 1842(a) of the Act authorized CMS to contract with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers).¹ Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process providers' claims, carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File (CWF). These systems can detect certain improper payments during prepayment validation.

CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. During calendar years (CY) 2003–2005, providers nationwide submitted approximately 2.3 billion claims to carriers. Of these, 29,022 claims resulted in payments of \$10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

Palmetto GBA

Palmetto GBA (Palmetto) is the Railroad Medicare Part B carrier for providers. During CYs 2004–2006, Palmetto processed more than 37 million Part B claims, 145 of which resulted in payments of \$10,000 or more (high-dollar payments).

“Medically Unlikely” Edits

In January 2007, after our audit period, CMS required carriers to implement units-of-service edits referred to as “medically unlikely” edits. These edits are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the “Medicare Program Integrity Manual,” Publication 100-08, Transmittal 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, Healthcare Common Procedure Coding System code, date of service, and billing provider against a specified number of units of service. Carriers must deny the entire claim line when the units of service billed exceed the specified number.

¹The Medicare Modernization Act of 2003, Pub. L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace carriers and fiscal intermediaries by October 2011.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Palmetto's high-dollar Railroad Medicare payments to Part B providers were appropriate.

Scope

We reviewed the 145 high-dollar payments totaling \$2,094,830 that Palmetto processed during CYs 2004-2006. We limited our review of Palmetto's internal controls to those applicable to the 145 high-dollar 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 the National Claims History file, but we did not assess the completeness of the file.

We performed our fieldwork from August 2007 through May 2008. Our fieldwork included contacting Palmetto, located in Augusta, Georgia, and the providers which received high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify Medicare Part B claims with high-dollar payments;
- reviewed available CWF claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;
- analyzed CWF data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and
- coordinated our claim review, including the calculation of any overpayments, with Palmetto.

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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDING AND RECOMMENDATION

Of the 145 high-dollar payments that Palmetto paid to providers, 137 were appropriate. Palmetto overpaid eight providers \$110,905 for the remaining claims.

The providers attributed the incorrect claims to clerical errors or insufficient documentation to support the units billed.

In addition, Palmetto made the overpayments because providers incorrectly submitted claims and the Medicare claim processing systems did not have sufficient edits in place during CYs 2004–2006 to detect and prevent payments for these types of erroneous claims. However, in January 2007, Palmetto implemented CMS-required units-of-service edits referred to as “medically unlikely” edits to suspend potentially excessive Medicare payments for prepayment review.

MEDICARE REQUIREMENTS

The CMS “Carriers Manual,” Publication 14, Part 2, section 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and instructions. Section 5261.3 of the manual requires carriers to effectively and continually analyze “data that identifies aberrancies, emerging trends and areas of potential abuse, overutilization or inappropriate care, and . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes.”

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Palmetto made overpayments totaling \$110,905 for eight high-dollar claims:

- For two claims, the providers stated that they billed incorrect procedure codes due to clerical errors. As a result, Palmetto overpaid the providers \$42,693.
- For two claims, the providers stated that they billed incorrect units of service due to clerical errors. As a result, Palmetto overpaid the providers \$31,905.
- For two claims, the providers did not address the reason why they billed the incorrect units of service. The providers simply stated that the units of service were billed incorrectly. As a result, Palmetto overpaid the providers \$18,625.
- For one claim, the provider stated that it did not have sufficient documentation for the claim; therefore, we identified each unsupported unit of service as an error. As a result, Palmetto overpaid the provider \$16,298.

- For one claim, the provider stated it had refunded an overpayment for the claim; however, the provider had no documentation of the refund and Palmetto stated the provider had not refunded the claim. As a result, Palmetto overpaid the provider \$1,384.

CAUSES OF INCORRECT PAYMENTS

The providers attributed the incorrect claims to clerical errors or insufficient documentation to support the units billed. In addition, during CYs 2004–2006, the Medicare Multi-Carrier Claims System and the CMS CWF did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider overpayments.² However, in January 2007, Palmetto implemented CMS-required units-of-service edits referred to as “medically unlikely” edits to suspend potentially excessive Medicare payments for prepayment review.

RECOMMENDATION

We recommend that Palmetto recover the \$110,905 in overpayments.

PALMETTO GBA COMMENTS

In its July 18, 2008 written comments on our draft report, Palmetto stated that it had initiated recovery of the \$110,905 in overpayments. The complete text of Palmetto’s comments is included as the Appendix.

²The carrier sends a “Medicare Summary Notice” to the beneficiary after the provider files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX

**Palmetto GBA**

PARTNERS IN EXCELLENCE

Gina Jenkins
Senior Director
RRB Program Manager

July 18, 2008

Peter J. Barbera
Regional Inspector General
for Audit Services, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

REF: Report Number: A-04-07-06026

Dear Mr. Barbera:

I am writing in response to the draft report received June 18, 2008 entitled "Review of High-Dollar Payments for Medicare Part B Claims Processed by Palmetto GBA, Railroad Benefit Contractor #880, for the period January 1, 2004, through December 31, 2006."

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. During calendar years (CY) 2003 - 2005, providers nationwide submitted approximately 2.3 billion claims to carriers. Of these, 29,022 claims resulted in payments of \$10,000 or more (high-dollar payments.) We consider such claims to be at high risk for overpayments.

Palmetto GBA is the Railroad Medicare Part B carrier for providers. During CYs 2004-2006, Palmetto GBA processed more than 37 million Part B claims, 145 of which resulted in payments of \$10,000 or more (high-dollar payments.)

OBJECTIVE

The objective of your review was to determine whether the high-dollar payments made to Railroad Medicare Part B providers were appropriate.

FINDINGS AND RECOMMENDATIONS

Of the 145 high-dollar payments that were made to providers, 137 were appropriate, 8 providers were overpaid at a combined total of \$110,905. The overpayments were attributed to providers submitting incorrect claim information, coding errors on the claims, and insufficient documentation to support the number of units billed.

It was recommended that Palmetto GBA recover the \$110,905.

RESPONSE

Palmetto GBA agrees with the recommendation to collect the overpaid amount of \$110,905. We have thoroughly reviewed the 8 claims that were paid in error. In all cases the provider was found to be at fault, Palmetto GBA processed the claims as they were submitted. The 8 claims have been referred to our account receivable unit to initiate recoupment of the overpayments for a total amount of \$110,905. In January 2007, Palmetto GBA implemented CMS required units-of-service edits. We also suspend claims that qualify as high-dollar payments for review prior to adjudication.

~~Peter J. Barbera~~
July 18, 2008
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Palmetto GBA appreciates the opportunity to be included in this review. It is our goal that the Medicare Trust Fund be upheld with integrity from the Medicare contractor and provider community perspective.

If you have any questions in regards to this response, please contact me at (706) - 855-3371.

Sincerely,



Gina Jenkins
Senior Director
Railroad Medicare Administration

CC Bruce Hughes
Joe Giansante