



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

October 6, 2008

Report Number: A-05-08-00030

Mr. Bruce Hughes  
President and Chief Operating Officer  
Palmetto GBA  
17 Technology Circle  
Columbia, South Carolina 29203

Dear Mr. Hughes:

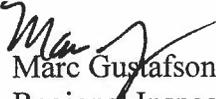
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Excessive Payments for Medicare Part B Services Processed by Palmetto GBA in Ohio for Calendar Years 2004 Through 2006." We will forward a copy of this report to the 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 Public Law 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 part 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 Jaime Saucedo, Audit Manager, at (312) 353-8693 or through e-mail at [Jaime.Saucedo@oig.hhs.gov](mailto:Jaime.Saucedo@oig.hhs.gov). Please refer to report number A-05-08-00030 in all correspondence.

Sincerely,

  
Marc Gustafson  
Regional Inspector General  
for Audit Services

Enclosure

**Direct Reply to HHS Action Official:**

Ms. Nanette Foster Reilly  
Consortium Administrator  
Consortium for Financial Management and Fee for Service Operations  
Centers for Medicare and Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF  
EXCESSIVE PAYMENTS FOR  
MEDICARE PART B SERVICES  
PROCESSED BY  
PALMETTO GBA IN OHIO FOR  
CALENDAR YEARS 2004  
THROUGH 2006**



Daniel R. Levinson  
Inspector General

October 2008  
A-05-08-00030

# ***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 Medicare Part B carrier for 38,592 providers in Ohio. During calendar years (CY) 2004 through 2006, Palmetto processed more than 112 million Part B claims, 844 of which resulted in payments of \$10,000 or more (high-dollar payments). Of the 844, Palmetto made 72 payments, totaling \$1,291,234, to 44 providers that each received less than 10 high-dollar payments. Three providers that received six high-dollar payments, totaling \$214,205, were no longer in business. As a result, we limited our review to the 66 high-dollar payments made to existing providers.

### **OBJECTIVE**

Our objective was to determine whether high-dollar Medicare payments that Palmetto made to Part B providers were appropriate.

### **SUMMARY OF FINDING**

Of the 66 high-dollar payments that Palmetto made to providers for Part B services for CYs 2004 through 2006, 34 were appropriate. The remaining 32 payments included overpayments totaling \$411,507. At the start of our audit, providers had:

- refunded overpayments totaling \$166,833 for 11 claims and
- not refunded overpayments totaling \$244,674 for 21 claims.

Palmetto made the overpayments because providers incorrectly billed excessive units of service and used inaccurate Health Care Procedure Coding System (HCPCS) codes. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004 through 2006 to detect and prevent payments for these types of erroneous claims.

## **RECOMMENDATIONS**

We recommend that Palmetto:

- recover the \$244,674 in identified overpayments and
- consider reviewing and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2006.

## **PALMETTO COMMENTS**

In written comments on our draft report, Palmetto agreed with the recommendations and stated that it had recovered all overpayments with the exception of one for \$10,727. Palmetto stated that it will follow up on the outstanding overpayment. Palmetto'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 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).<sup>1</sup> 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. 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) 2004 through 2006, providers nationwide submitted approximately 2.4 billion claims to carriers. Of these, 31,576 claims resulted in payments of \$10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

#### Palmetto

Palmetto GBA (Palmetto) is the Medicare Part B carrier for 38,592 providers in Ohio. During CYs 2004 through 2006, Palmetto processed more than 112 million Part B claims, 844 of which resulted in high-dollar payments. Of the 844, Palmetto made 72 payments, totaling \$1,291,234, to 44 providers that each received less than 10 high-dollar payments. Three providers that received six high-dollar payments, totaling \$214,205, were no longer in business.<sup>2</sup> As a result, we limited our review to the 66 high-dollar payments made to existing providers.

#### “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.

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<sup>1</sup>The 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.

<sup>2</sup>One provider filed for bankruptcy, one retired, and one went out of business.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether high-dollar Medicare payments that Palmetto made to Part B providers were appropriate.

### **Scope**

Palmetto made 844 high-dollar payments during CYs 2004 through 2006. Of the 844, Palmetto made 72 high-dollar payments, totaling \$1,291,234, to 44 providers that each received less than 10 high-dollar payments during CYs 2004 through 2006. We were unable to review 6 of the 72 high-dollar payments made to 3 providers because the providers were no longer in business. Therefore, we limited our review to the 66 high-dollar payments totaling \$1,077,029 made to existing providers.

Of the 66 high-dollar payments, providers had previously identified and refunded overpayments, totaling \$166,833, for 11 claims prior to the start of our fieldwork. For these payments, we limited our review to obtaining evidence that providers refunded the overpayments.

We will review and report on the remaining 772 high-dollar payments made to providers that each received 10 or more high dollar-payments during CYs 2004 through 2006 in a separate report.

We limited our review of Palmetto's internal controls to those applicable to the 66 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 conducted fieldwork from January through March 2008 by contacting Palmetto, located in Columbus, Ohio, and the 41 providers that received the Medicare reimbursement for claims reviewed.

### **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 Common Working File claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims and whether payments remained outstanding at the time of our fieldwork;

- 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 to ensure overpayments occurred and refunds were appropriate.

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.

### **FINDING AND RECOMMENDATIONS**

Of the 66 high-dollar payments that Palmetto made to providers for Part B services for CYs 2004 through 2006, 34 were appropriate. The remaining 32 payments included overpayments totaling \$411,507. At the start of our audit, providers had:

- refunded overpayments totaling \$166,833 for 11 claims and
- not refunded overpayments totaling \$244,674 for 21 claims.

Palmetto made the overpayments because providers incorrectly billed excessive units of service and used inaccurate Health Care Procedure Coding System (HCPCS) codes. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004 through 2006 to detect and prevent payments for these types of erroneous claims.

### **FEDERAL 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 \$244,674, to 17 providers for 21 claims because the providers incorrectly billed excessive units of service and used inaccurate HCPCS codes. The following examples illustrate the high-dollar overpayments:

- For one payment, a provider reported 600 units of service but only provided 60 units, a difference of 540 units of service. As a result, Palmetto paid the provider \$23,933 when it should have paid \$2,393, a \$21,540 overpayment.

- For one payment, a provider inaccurately reported HCPCS code A9543 instead of the correct HCPCS code A9542. As a result, Palmetto paid the provider \$31,815 when it should have paid \$19,181, a \$12,634 overpayment.

## **CAUSES OF OVERPAYMENTS**

Providers attributed the incorrect claims to clerical errors made by their billing staffs. In addition, during CYs 2004 through 2006, the Medicare Multi-Carrier Claims System and the CMS Common Working File 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.<sup>3</sup>

## **RECOMMENDATIONS**

We recommend that Palmetto:

- recover the \$244,674 in identified overpayments and
- consider reviewing and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2006.

## **PALMETTO COMMENTS**

In written comments on our draft report, Palmetto agreed with the recommendations and stated that it had recovered all overpayments with the exception of one for \$10,727. Palmetto stated that it will follow up on the outstanding overpayment. Palmetto’s comments are included in their entirety as the Appendix.

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<sup>3</sup>The 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™

Bruce W. Hughes  
President and Chief Operating Officer

September 15, 2008

Mr. Marc Gustafson  
Department of Health and Human Services  
Office of Inspector General (OIG)  
Office of Audit Services  
233 North Michigan Avenue  
Chicago, Illinois 60601

Dear Mr. Gustafson:

This is in response to your letter dated August 19, 2008 detailing the draft report for the Ohio Medicare Part B claims processed by Palmetto GBA for the calendar years 2004 through 2006, report number: A-05-08-00030. The letter requested that Palmetto GBA provide written comments to include actions taken on your recommendations.

The objective of the review of the high dollar payments for Ohio was to determine whether Palmetto GBA payments were appropriate. Based upon your review of our high dollar payments, you determined that of the universe of 844 claims with payments exceeding \$10,000, Palmetto GBA made 72 high dollar payments totaling \$1,291,234 to 44 providers. Three providers that received a total of six high dollar payments totaling \$214,205 are no longer in business. As a result, you limited your review to the 66 high-dollar payments made to the existing providers.

Of the 66 claims reviewed, 34 payments were appropriate. The remaining 32 payments resulted in overpayments totaling \$411,507. At the start of the audit, you determined providers had already refunded overpayments totaling \$166,833 for 11 claims and refunds remained outstanding for 21 claims.

Based upon Palmetto GBA's review of the claims and information provided, Palmetto GBA concurs that the majority of the overpayments were the result of provider billing errors. A review of our records and subsequent follow up with our financial area indicates that all of the overpayments have been recovered with the exception of one in the amount of \$10,727.19. The AR letter was issued on September 4, 2008. We will continue to follow up to ensure the refund is received. If not received, the overpayment will ultimately be sent to the Department of Treasury for collection.

Additional editing to minimize inappropriate payments of high dollar claims was implemented in May, 2005. This edit suspends claims with a billed amount of \$10,000 or more for manual review. Six of the claims containing overpayments were submitted and processed prior to the implementation of the high dollar edit. The remaining overpayments occurred as a result of incorrect submissions by the billing staffs.

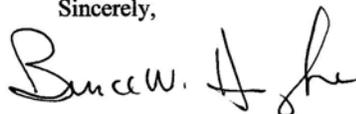
Mr. Marc Gustafson  
September 15, 2008  
Page 2

As stated in our letter dated September 3, 2008, as part of our continuing efforts to improve our service, Palmetto GBA is also reviewing the effectiveness of the high dollar edit. In addition, handling of the claims is now limited to claims analysts specifically trained on the high dollar edit to promote consistency and accuracy in the processing of the high dollar claims while strengthening the overall control of the process. Also, refresher training was conducted for all staff currently processing the high dollar edit claims in April 2008. As further precaution, we intend to review a number of high dollar claims containing dates of service after the implementation of the edit to determine if additional controls are needed to ensure the safeguards of program funds.

In addition to the high dollar edit mentioned above, the Medically Unlikely Edits (MUE) were implemented in accordance with the CMS directive in October 2007. Palmetto GBA is also working to implement additional edits that will further enhance controls to detect quantity billed errors by initially establishing recommended dosages for drugs. As part of this initiative, we will coordinate with our medical staff to prioritize review of the procedure codes involved in the overpayments to determine if there are other controls that can be utilized to minimize future overpayments associated with these specific codes.

Please do not hesitate to contact Gary Zapf at 614-473-7117, if you require additional information.

Sincerely,



cc: Gary W. Zapf, Senior Director