



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

REGION V
OFFICE OF
INSPECTOR GENERAL

October 2, 2008

Report Number: A-05-08-00031

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 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. Please refer to report number A-05-08-00031 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 12th 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-05-08-00031

Office of Inspector General

<http://oig.hhs.gov>

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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 772 payments, totaling \$17 million, to 10 providers that each received 10 or more high-dollar payments.

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 772 high-dollar payments that Palmetto made to providers, 765 were appropriate. However, Palmetto made net overpayments totaling \$19,235 for seven Part B high-dollar payments, which had not been repaid at the start of our audit. Palmetto made the overpayments because the providers mistakenly reported services that were not provided and reported inaccurate units of service and Palmetto staff made a data entry error when making a payment. 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 \$19,235 in identified net 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 the seven claims representing overpayments of \$19,235 were adjusted and monies were recovered. 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).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. 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 772 payments, totaling \$17 million, to 10 providers that each received 10 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

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

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

Scope

Palmetto made 844 high-dollar payments during CYs 2004 through 2006. We reviewed 772, totaling \$17,061,380, that Palmetto processed during CYs 2004 through 2006 for 10 providers that each received 10 or more high-dollar payments. We will review and report on the remaining 72 high-dollar payments in a separate report.

We limited our review of Palmetto's internal controls to those applicable to the 772 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 10 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 Medicare 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 the providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and
- validated with Palmetto that 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 772 high-dollar payments that Palmetto made to providers, 765 were appropriate. However, Palmetto made net overpayments of \$19,235 for the remaining seven payments, which had not been repaid at the start of our audit. Palmetto made the overpayments because providers mistakenly reported services that were not provided and reported inaccurate units of service and Palmetto staff made a data entry error when making a payment. 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 net overpayments, totaling \$19,235, to two providers on seven payments because the providers mistakenly reported services that were not provided and reported inaccurate units of service. For two of the seven payments, Palmetto underpaid the provider for one unit of service.

Services Not Provided

A provider inappropriately claimed reimbursement totaling \$17,424 for services that were not provided. The provider mistakenly reported the services provided to a non-Medicare beneficiary as being provided to the individual’s brother, who was a Medicare beneficiary.

Units of Service

For six net overpayments, totaling \$1,811, providers reported inaccurate units of service:

- For three payments, a provider reported 221 units of service when it should have reported 210 units of service. As a result, Palmetto paid the provider \$33,264 when it should have paid \$32,256, a \$1,008 overpayment.
- For one payment, a provider reported 222 units of service but only provided 132 units, a difference of 90 units of service. As a result, Palmetto paid the provider \$11,417 when it should have paid \$10,454, a \$963 overpayment.

- For one payment, the provider reported 430 units of service when it should have reported 431 units of service. As a result, Palmetto paid the provider \$36,120 when it should have paid \$36,204, an \$84 underpayment.
- For one payment, Palmetto mistakenly paid \$24,168 for 318 units of service when it should have paid \$24,244 for 319 units of service, a \$76 underpayment.

CAUSES OF OVERPAYMENTS

Providers attributed the incorrect claims to data entry errors made by their billing staffs and Palmetto made a data entry error when making a payment. 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.²

RECOMMENDATIONS

We recommend that Palmetto:

- recover the \$19,235 in identified net 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 the seven claims representing overpayments of \$19,235 were adjusted and monies were recovered. Palmetto’s comments are included in their entirety 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



Bruce W. Hughes
President and Chief Operating Officer

September 3, 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 8, 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-05-08-00031. The letter requested that Palmetto GBA provide written comments to include actions taken on your recommendations. A separate response will be sent regarding A-05-08-00030 that was received on August 29, 2008.

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 772 high dollar payments reviewed 765 were appropriate. Palmetto GBA made net overpayments to providers totaling \$19,235 on the remaining claims.

Based upon Palmetto GBA's review of the claims and information provided, Palmetto GBA concurs that 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.

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. Three of the five claims containing overpayments were submitted and processed prior to the implementation of the high dollar edit. The remaining claims suspended for review. The overpayments occurred as a result of incorrect submissions by the billing staffs.

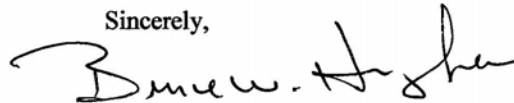
As part of our continuing efforts to improve our service, Palmetto GBA is also reviewing the effectiveness of the high dollar edit and considering limiting the handling of high dollar claims to the most experienced claims analysts to promote consistency and accuracy in the processing of the high dollar 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.

Mr. Marc Gustafson
September 3, 2008
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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. The first of the new edits is expected to be implemented by October 1, 2008.

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

Sincerely,

A handwritten signature in black ink, appearing to read "Bruce A. Hays". The signature is written in a cursive style with a large initial "B".

cc: Gary W. Zapf, Senior Director