



April 13, 2010

TO: Charlene Frizzera
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Joseph E. Vengrin/
Deputy Inspector General for Audit Services

SUBJECT: Review of National Government Services, Inc., Medicare Payments to Providers Terminated Between January 1, 2003, and January 31, 2007 (A-05-09-00035)

Attached, for your information, is an advance copy of our final report on National Government Services, Inc. (NGS), Medicare payments to providers terminated between January 1, 2003, and January 31, 2007. We will issue this report to NGS within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or James C. Cox, Regional Inspector General for Audit Services, Region V, at (312) 353-2621 or through email at James.Cox@oig.hhs.gov. Please refer to report number A-05-09-00035.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services, Region V
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601

April 20, 2010

Report Number: A-05-09-00035

Ms. Sandy Miller
President
National Government Services, Inc.
8115 Knue Road
Indianapolis, IN 46250

Dear Ms. Miller:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of National Government Services, Inc., Medicare Payments to Providers Terminated Between January 1, 2003, and January 31, 2007*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me, or contact David Markulin, Audit Manager, at (312) 353-1644 or through email at David.Markulin@oig.hhs.gov. Please refer to report number A-05-09-00035 in all correspondence.

Sincerely,

/James C. Cox/
Regional Inspector General
for Audit Services

Enclosure

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, MO 64106

Department of Health & Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF NATIONAL
GOVERNMENT SERVICES, INC.,
MEDICARE PAYMENTS TO
PROVIDERS TERMINATED
BETWEEN JANUARY 1, 2003,
AND JANUARY 31, 2007**



Daniel R. Levinson
Inspector General

April 2010
A-05-09-00035

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health & Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at <http://oig.hhs.gov>

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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 Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, uses Medicare contractors, such as fiscal intermediaries (FI), to process and pay Medicare claims submitted by health care providers. Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act to require that Medicare administrative contractors (MAC) replace FIs and carriers by October 2011.

Medicare contractors, such as FIs and MACs, must comply with Medicare laws, regulations, and guidance, including provisions for processing payments to terminated or sanctioned Medicare providers. Section 1866(b) of the Act provides for the termination of provider agreements, which set forth the terms and conditions for participation in the Medicare program. Sections 1814(a) and 1866 of the Act generally do not allow payment for services provided on or after an agreement's termination date. Pursuant to section 1819(h)(2)(B)(i) of the Act, CMS may impose a denial of payment for new admissions (DPNA) sanction on skilled nursing facilities that fail to comply with Medicare requirements. The *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 6, section 50, denies payment for Medicare Part A services provided to beneficiaries initially admitted during a DPNA sanction period. The *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, requires Medicare contractors to maintain internal controls to prevent erroneous payments; chapter 3 requires Medicare contractors to pursue recovery of overpayments, including those made to terminated or sanctioned Medicare providers.

Empire HealthChoice Assurance, Inc. (Empire), was an FI during our audit period (January 1, 2003, through January 31, 2007). However, this report refers to the auditee as "National Government Services, Inc." (NGS), because in January 2007, NGS assumed the FI business operations of Empire. CMS subsequently awarded NGS two MAC contracts for the administration of Medicare Part A and Part B claims.

OBJECTIVE

Our objective was to determine whether NGS recovered Medicare overpayments for services furnished on or after the effective termination dates of provider agreements or during termination-related DPNA sanction periods.

SUMMARY OF FINDING

NGS did not always recover Medicare overpayments for services furnished on or after the effective termination dates of provider agreements or during termination-related DPNA sanction periods. For 59 of the 64 terminated providers whose payments we reviewed, NGS had not made material overpayments that were subject to recovery as of the start of our audit. However,

for the five remaining providers, NGS had not recovered a total of \$1,221,342 in overpayments that were subject to recovery. NGS had not recovered \$1,159,522 of this total because it did not follow its procedures to retroactively identify payments for posttermination services. NGS had not recovered the remaining \$61,820 because it had not yet implemented written DPNA-related procedures. NGS confirmed that the overpayments were subject to recovery.

RECOMMENDATIONS

We recommend that NGS:

- recover \$1,221,342 in overpayments to the five terminated providers and
- follow its procedures to retroactively identify and recover overpayments for services furnished on or after the providers' effective termination dates.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, NGS agreed with our recommendations and provided information on the status of its claim adjustments. NGS's comments, except for sensitive information, are included as the Appendix.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Program.....	1
Medicare Payment Requirements	1
National Government Services, Inc.	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope.....	2
Methodology.....	2
FINDING AND RECOMMENDATIONS	3
FEDERAL REQUIREMENTS	3
OVERPAYMENTS NOT RECOVERED	3
RECOMMENDATIONS	4
NATIONAL GOVERNMENT SERVICES COMMENTS	4
APPENDIX	
NATIONAL GOVERNMENT SERVICES COMMENTS	

INTRODUCTION

BACKGROUND

Medicare Program

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, uses Medicare contractors, such as fiscal intermediaries (FI), to process and pay Medicare claims submitted by health care providers. Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act to require that Medicare administrative contractors (MAC) replace FIs and carriers by October 2011.

Medicare Payment Requirements

Medicare contractors, such as FIs and MACs, must comply with Medicare laws, regulations, and guidance, including provisions for processing payments to terminated or sanctioned Medicare providers. Section 1866(b) of the Act provides for the termination of provider agreements, which set forth the terms and conditions for participation in the Medicare program. Sections 1814(a) and 1866 of the Act generally do not allow payment for services provided on or after an agreement's termination date. Pursuant to section 1819(h)(2)(B)(i) of the Act, CMS may impose a denial of payment for new admissions (DPNA) sanction on skilled nursing facilities (SNF) that fail to comply with Medicare requirements. The *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 6, section 50, denies payment for Medicare Part A services provided to beneficiaries initially admitted during a DPNA sanction period. The *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, requires Medicare contractors to maintain internal controls to prevent erroneous payments; chapter 3 requires Medicare contractors to pursue recovery of overpayments, including those made to terminated or sanctioned Medicare providers.

National Government Services, Inc.

Empire HealthChoice Assurance, Inc. (Empire), was an FI during our audit period (January 1, 2003, through January 31, 2007). However, this report refers to the auditee as "National Government Services, Inc." (NGS), because in January 2007, NGS assumed the FI business operations of Empire. CMS subsequently awarded NGS two MAC contracts for the administration of Medicare Part A and Part B claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether NGS recovered Medicare overpayments for services furnished on or after the effective termination dates of provider agreements or during termination-related DPNA sanction periods.

Scope

We reviewed NGS payments to 64 providers with effective termination dates between January 1, 2003, and January 31, 2007. The reviewed payments were for services furnished on or after the providers' effective termination dates or during a termination-related DPNA sanction period.¹ We limited our review of internal controls to discussing with NGS officials the procedures used to retroactively identify and recover the overpayments identified during our review.

Our fieldwork included contacting NGS in Indianapolis, Indiana, and Louisville, Kentucky.

Methodology

To accomplish our objective, we:

- used a CMS nationwide list of providers with effective termination dates during the audit period to query the National Claims History files;
- identified 64 NGS-serviced providers that received Medicare payments for services furnished during or after our audit period;
- analyzed CMS, National Claims History, and NGS data and identified five providers that each received \$5,000 or more in overpayments for services furnished on or after the providers' effective termination dates or during a termination-related DPNA sanction period; and
- worked with NGS to quantify the overpayments that were subject to recovery as of the start of our audit.

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 finding and conclusions based on our audit objective.

¹ We reviewed NGS payments for services furnished during a DPNA sanction period only if the DPNA was referenced in the termination documents that we reviewed.

FINDING AND RECOMMENDATIONS

NGS did not always recover Medicare overpayments for services furnished on or after the effective termination dates of provider agreements or during termination-related DPNA sanction periods. For 59 of the 64 terminated providers whose payments we reviewed, NGS had not made material overpayments that were subject to recovery as of the start of our audit. However, for the five remaining providers, NGS had not recovered a total of \$1,221,342 in overpayments that were subject to recovery. NGS had not recovered \$1,159,522 of this total because it did not follow its procedures to retroactively identify payments for posttermination services. NGS had not recovered the remaining \$61,820 because it had not yet implemented written DPNA-related procedures. NGS confirmed that the overpayments were subject to recovery.

FEDERAL REQUIREMENTS

Section 1814(a) of the Act provides that “payment for services furnished an individual may be made only to providers of services which are eligible therefor under section 1866 [which sets forth the requirements for provider agreements]” Pursuant to section 1866(b)(2) of the Act and 42 CFR §§ 489.53 and 489.54, CMS or the Office of Inspector General may terminate a provider agreement for cause. Additionally, section 1866(b)(1) of the Act and 42 CFR § 489.52 permit a Medicare provider to voluntarily terminate its provider agreement. Except in certain limited circumstances considered during this audit, such as those described in 42 CFR § 489.55, no Medicare payment is available for services furnished to a beneficiary on or after the effective date of termination of a provider agreement.

Section 1819(h)(2)(B)(i) of the Act and 42 CFR § 488.417(a)(1) permit CMS to impose a DPNA sanction on SNFs that are not in substantial compliance with Medicare requirements. In addition, pursuant to 42 CFR § 488.417(b), CMS is required to impose a DPNA sanction when a SNF (1) “is not in substantial compliance ... 3 months after the last day of the survey identifying the noncompliance ...” or (2) has been cited “with substandard quality of care on the last three consecutive standard surveys.” The sanction applies only to a “new admission,” which 42 CFR § 488.401 defines as “a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date.”² The *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 6, section 50.1, provides that the DPNA sanction applies to “days that would otherwise be Part A-payable; i.e., the care is covered but no payment will be made to the provider.”

The *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, requires Medicare contractors to maintain internal controls to prevent and detect erroneous payments; chapter 3 requires Medicare contractors to pursue recovery of overpayments.

OVERPAYMENTS NOT RECOVERED

As of the start of our audit, NGS had not recovered overpayments to five providers. Providers A, B, D, and E in the table on the next page received Medicare overpayments for services furnished

² In addition, 42 CFR § 488.401 provides that “[r]esidents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment.”

on or after the providers' effective termination dates. Provider C, a terminated SNF, received overpayments for new admissions during a termination-related DPNA sanction period. NGS confirmed that these overpayments were subject to recovery.

Unallowable Claims and Overpayments

	Unallowable Claims	Overpayments
Provider A	511	\$970,056
Provider B	64	148,516
Provider C	23	61,820
Provider D	581	31,002
Provider E	12	9,948
Total	1,191	\$1,221,342

NGS did not recover the overpayments to providers A, B, D, and E before our audit because it did not follow its procedures to retroactively identify and recover the payments. Although NGS stated that such procedures were in place, it could not locate written procedures. As a result of our audit, NGS updated and formalized its procedures effective March 2009.

NGS did not recover the overpayments to provider C before our audit because it had not yet developed written DPNA-related procedures. However, NGS implemented these procedures in February 2007.

RECOMMENDATIONS

We recommend that NGS:

- recover \$1,221,342 in overpayments to the five terminated providers and
- follow its procedures to retroactively identify and recover overpayments for services furnished on or after the providers' effective termination dates.

NATIONAL GOVERNMENT SERVICES COMMENTS

In written comments on our draft report, NGS agreed with our recommendations and provided information on the status of its claim adjustments. NGS's comments, except for sensitive information, are included as the Appendix.

APPENDIX

APPENDIX: NATIONAL GOVERNMENT SERVICES COMMENTS



National Government Services, Inc.
P.O. Box 7181
Indianapolis, Indiana 46207-7181
A CMS Contracted Agent

Medicare

February 26, 2010

Mr. Stephen Slamar
Acting Regional Inspector General for Audit Services
Office of Audit Services, Region V
223 North Michigan Avenue
Suite 1360
Chicago, IL 60601

Re: NGS Response to OIG Audit, Report Number: A-05-09-00035

Dear Mr. Slamar:

This letter is in response to the above referenced draft we received January 22, 2010, entitled "Review of National Government Services Inc., Medicare Payments to Providers Terminated Between January 1, 2003 and January 31, 2007."

National Government Services (NGS) agrees with the audit recommendations noted in the draft report. Please see the table below that outlines the status of claim adjustments necessary to recoup the overpayments made during this period

Provider ID	Unallowable Claims	Overpayments	Provider #	Completed Adj	Adj in SMTERM*	Incomplete Adj	Invalid HIC#s	\$0.00 Adj	Total
Provider A	511	\$ 970,056	██████	143	368				
				\$18,018	\$952,039				
Provider B	64	\$ 148,516	██████	63		1			
				\$146,191		\$2,325			
Provider C	23	\$ 61,820	██████	21	2				
				\$56,454	\$5,366				
Provider D	581	\$ 31,002	██████	547		14	7	13	
				\$30,061		\$773	\$168	0	
Provider E	12	\$ 9,948	██████	10	2				
				\$4,128	\$5,820				
Total				784	372	15	7	13	1,191
				\$254,851	\$963,226	\$3,099	\$168	\$0	\$1,221,344

*SMTERM Suspended location for OIG adjustments - problem with SMCABL



Office of Inspector General Note—We have deleted sensitive information from this appendix.

Of the 1,191 original claims;

- 784 have been adjusted, recouping \$254,851.
- 372 have been adjusted but would not post to CWF due to a FISS problem [REDACTED]. This problem should be corrected with a fix in the April Quarterly release. With the correction of this situation and additional \$963,226 will be recouped.
- 15 adjustments were not completed due to the claims being off-line. Those claims are being retrieved and once completed will result in the recoupment of \$3,099.
- 7 could not be adjusted due to invalid HIC numbers. These claims represented \$168.
- 13 claims did not involve overpayments.

NGS appreciates the opportunity to respond to the draft report. Should you have further questions, please feel free to contact Lawrence Bankston, Claims Manager, at 502-329-8574.

Sincerely,



David A. Marshall
Chief Operating Officer,
National Government Services, Inc.

cc: Sharon Weddel, Part A/RHHI Claims Director