

July 26, 2001

Our Reference: Common Identification No. A-02-00-01039

Ms. Gloria Lebrón, Esq.
Vice President
Medicare Division
Triple S, Inc.
P.O. Box 71391
San Juan, PR 00936-1391

Dear Ms Lebrón:

This report provides you with the results of our “REVIEW OF FISCAL YEAR 2000 MEDICARE ERROR RATE AT SEGUROS DE SERVICIOS DE SALUD DE PUERTO RICO”. Our review was required by the Chief Financial Officers (CFO) Act of 1990, as amended.

The objective of this aspect of the review was to assess claims processing operations at Seguros de Servicios de Salud de Puerto Rico (Triple S) that contributed to the preparation of the fiscal year (FY) 2000 combined financial statements for the Centers for Medicare and Medicaid Services (CMS)¹. A separate report (CIN A-02-00-01021) has been issued on our CFO review of the accounting controls and financial activity at Triple S. Our audit included claims processed by Triple S during the first quarter of FY 2000, i.e., from October 1 through December 31, 1999.

The review identified areas with respect to claims processing where corrective actions are needed to comply with applicable laws and regulations and prevent material misstatement of the CMS financial statements. Specifically, our sample of 680 claims identified 68 claims that did not comply with Medicare laws and regulations. These errors were detected through medical review of supporting documentation and detailed testing by OIG auditors. Contributing significantly to the errors noted during the course of the review was the fact that provider records did not completely and accurately support amounts reimbursed by Medicare.

We are recommending that Triple S (1) recover improper payments made for the sample claims and (2) reinforce certain billing requirements through provider bulletins and education.

¹ Formerly known as the Health Care Financing Administration (HCFA).

INTRODUCTION

Background

Medicare was established under Title XVIII of the Social Security Act by the Social Security Amendments of 1965. At the Federal level, Medicare is administered by CMS. To accomplish its mission, CMS contracts with Fiscal Intermediaries (FIs) and Carriers to process Medicare claims submitted by health care providers. The CMS instructions to FIs and Carriers are included in the Medicare Intermediary Manual (MIM) and the Carriers Manual, respectively.

Under contract with CMS, Triple S is a Carrier that processes Medicare claims for providers located in the Commonwealth of Puerto Rico and the U.S. Virgin Islands. As such, Triple S is responsible for pricing covered medical items and services, making claims payments, guarding against the unnecessary use of medical services, and reporting financial activity to CMS. Claims are processed by Triple S using the Viable Information Processing System, or VIPS, Medicare System (VMS) with a data processing center at Alabama. During FY 2000, Triple S reported processing 7,345,415 Medicare Part B claims totaling \$466,699,922.77.

Objectives, Scope and Methodology

The objective of our review was to assess claims processing operations at Triple S that contributed to the preparation of the FY 2000 combined financial statements for CMS. The scope of our audit included a review of the controls and operations related to the claims processing operations at Triple S for the first quarter of FY 2000. Using statistical sampling techniques, we selected Medicare claims processed for payment during the first quarter of FY 2000 for detailed review. For the first quarter of FY 2000, Triple S reported processing 2,039,050 Medicare Part B claims totaling \$113,954,521.38.

Upon reconciling the monthly CMS filings to Triple S paid claims tapes², a sample of 50 Medicare beneficiaries for detailed testing was selected for the sampled quarter. This phase of the review included testing by our auditors and Triple S's medical review staff to assure beneficiary and provider eligibility, timely filing and the propriety of deductible, coinsurance and provider reimbursement amounts. It also included tests to ensure that Medicare only paid for allowable services and had not issued duplicate payments.

Field work was performed during the period July through December 2000 at our San Juan field office in Hato Rey and the Triple S-Medicare facilities in Puerto Nuevo, Puerto Rico. This audit was conducted in accordance with generally accepted government auditing standards.

² Our separate report (Common Identification Number A-02-00-01021) on the review of accounting controls and financial activity discusses the results of the CFO reconciliation at Triple S.

FINDINGS AND RECOMMENDATIONS

The review identified certain areas where corrective actions are needed to comply with applicable laws and regulations and prevent material misstatement of the CMS financial statements. Specifically, the review identified 68 claims (with improper payments totaling \$4,741.04) that did not comply with Medicare laws and regulations. The improper payments represent an error rate of 5.44% of the total payments of \$87,206.98 in the sample. Most of these errors could only be detected through review of the supporting medical records and were found to be in error as detailed below:

Error Category	Error
No Documentation	1
Insufficient Documentation	5
Services Incorrectly Coded	
Services Provided by Someone Other than	2
Services Billed Were Not Rendered	
Duplicate Payment	2
Unbundling	1
Ineligible Provider	1
Total Claim Error Lines	96
Less Claims with Multiple Error Lines	28
Total Error Claims	68

Specific details regarding the errors identified by our review were provided to Triple S upon completion of our field work, to facilitate timely recoupment of the overpayments.

The Medicare program requires that medical services must be reasonable, medically necessary, and delivered in the appropriate setting. In addition, Section 482.24 (c) of Title 42 of the Code of Federal Regulations requires providers to maintain medical records that contain sufficient documentation to substantiate the nature and/or necessity of services furnished, diagnoses, treatments performed and continued care.

To illustrate, Triple S medical review staff identified the following situations:

Insufficient Documentation – The provider was paid \$62.06 for a prolonged physician service with direct (face to face) patient contact. The procedure code billed requires that the physician both spend at least 30 minutes with the patient on the given date and also provide a level of care beyond the usual evaluation and management services. The medical reviewer determined that medical records were not sufficient to reach an informed medical decision that patient contact, in excess of the evaluation and management service allowed for this date, had occurred. As a result, \$62.06 for this prolonged service was denied.

Services Incorrectly Coded - The provider was paid \$129.46 for critical care services to evaluate and manage the care of an unstable critically ill patient, procedure code 99291. The critical care codes are used to report the cumulative total time spent by a physician in providing constant attention to the patient on any given day. While code 99291 is appropriately used to report the first hour of critical care on a given date, critical care totaling less than 30 minutes on a given date should be reported with an appropriate evaluation and management code rather than with a critical care code. The medical reviewer determined that the services performed did not meet the minimum criteria described above because there was no evidence that the time spent with the patient exceeded 30 minutes. Instead, the medical reviewer determined that a problem focused interval history, an expanded problem focused examination, and medical decision making of moderate complexity, services that typically require less than 30 minutes, had been provided. Therefore, the medical reviewer downcoded this service to the appropriate evaluation and management code, procedure 99232. As a result, \$93.66 for this line of service was questioned.

Of particular concern, too, with respect to the incorrect coding of services was the fact that approximately 69 percent of the total found to be improperly paid related to claims for evaluation and management services, including critical care services, that were downcoded to lower paying codes upon review of the medical records.

Services Billed Were Not Rendered - The provider was paid \$126.59 for psychotherapy, medical evaluation and management services. The provider confirmed in writing that the services had not been performed and that a billing error had occurred. Based on this correspondence and review of the medical records submitted, the medical reviewer concluded that the services had not been rendered. Therefore, the total payment of \$126.59 was denied.

In July 2000, CMS implemented the Comprehensive Error Rate Testing (CERT) Program by awarding a contract to the DynCorp Payment Safeguard Contractor (DynCorp). For the FY 2000 CFO audits, the CERT included the requirement, among other tasks, that DynCorp assess the errors identified by the Medicare contractors' medical review staff. Upon their review of the medical records, DynCorp proposed a revision to only one of the 68 sampled claims.

Conclusion

As noted above, most of the improper payments were detected through review of the supporting medical records. In the majority of these instances, an incorrect procedure code had been billed for evaluation and management such as office, home and hospital visits and consultations and critical care services.

Recommendations

We recommend that Triple S:

- recover the improper payments of \$4,741.04 related to the sample claims, and
- remind providers, through bulletins and other provider education opportunities, of the billing requirements for the evaluation and management services, including the critical care procedure codes.

Triple S's Comments

The Triple S concurred with the findings and recommendations. Specifically, Triple S noted that they have recovered all of the improper payments identified by the audit and that they made plans to undertake provider education efforts focused on the billing requirements for evaluation and management services, including the critical care procedure codes. The full text of Triple S's comments is presented as an appendix to this report.

Office of Audit Services' Response

We thank Triple S for their cooperation in conducting the medical review aspects of this audit and hope that the proposed educational efforts will be successfully implemented.

A graphic consisting of three rectangular boxes. The central box is white with a black border and contains the word 'APPENDIX' in a black serif font. It is flanked by two smaller, empty white rectangular boxes with black borders. The bottom corners of the central box and the two side boxes are cut off at a 45-degree angle, creating a shadow effect.

APPENDIX



MEDICARE
 Part-B Carrier
 Prov. (787) 749-4232
 Bene. (787) 749-4900

July 16, 2001

Mr. Timothy J. Horgan
 Regional Inspector General for Audit Services
 DHHS, OIG/OAS
 26 Federal Plaza, 39th Floor
 New York, New York 10278

Ref: Common Identification Number A-02-00-01039

Dear Mr. Horgan:

This is in response to your letter dated June 15, 2001, regarding the Office of Inspector General’s “Review of Fiscal Year 2000 Medicare Error Rate at Triple-S, Inc.”

As the letter states, “OIG through their process of evaluation have identified areas with respect to claims processing where corrective actions are needed to comply with applicable laws and regulations and prevent material misstatement of CMS financial statements. The errors were detected through medical review of supporting documentation and detailed testing by the OIG auditors. Contributing significantly to the errors noted during the course of the review was the fact that provider records did not completely and accurately support amounts reimbursed by Medicare”. Specifically, OIG recommended that we should recover improper payments made for the sample claims and reinforce certain billing requirements through provider bulletins and education.

The following is this Carrier’s course of action as it relates to the recommendations presented by the OIG Auditors. Please note that our answers are in the same order that the recommendations are presented in the formal document submitted by OIG.

Recovery of Improper Payments:

As a result of the OIG review a total of 46 providers were identified as not complying with Medicare requirements as it pertains to maintaining proper records that accurately support amounts reimbursed by Medicare. Based on this information and as recommended by the OIG auditors, we initiated in February 2001 a recoupment process in order to recover the improper payments made to these providers. The overpayments, which have been totally recover, were collected as follow:

Number of Providers	Month Collected
2	February
18	March
15	April
9	May
2	June
TOTAL 46	

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Educational Campaign:

In order to comply with the recommendations presented by the OIG auditors, we will be promoting two methods of educating the provider community, one will be through the Medicare "Informa" newsletter and the other is face-to-face meetings. As part of our educational process to the providers, we will be emphasizing the importance of the coding at the proper level of complexity in the evaluation and management procedure codes in order to avoid down coding. The face-to-face meetings will be conducted with providers that within their specialties have the tendency of standing out among themselves. Our educational efforts to the provider community will be in reinforcing the importance of the proper documentation coinciding with the level billed.

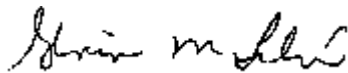
For FY 2002, our educational approach will be focused on specific utilization issues dealing with the high complexity level of E&M procedure codes. Our Medical Review Strategy Plan and the Quality Improvement Program will be directed at being more aggressive in the areas of prepayment and post payment medical reviews in order to be consistent with the goal of reducing the error rate.

Summary

We agreed that all of the recommendations enhancements suggested by the OIG are needed and we understand that they have been addressed accordingly.

Should you have any questions regarding this response or need additional information, please call me at (787) 749-4083.

Cordially,



Gloria M. Lebrón, Esq.
Vice President
Triple-S, Inc./Medicare

C: Elliot Hirshon, Audit Manager, OIG/OAS
Margie Colón, JD, Senior Auditor, OIG/OAS