DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

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

SEP 4 2008

Report Number: A-04-08-06009

Mr. Bruce W. Hughes
President and Chief Operating Officer
Palmetto GBA
2300 Springdale Drive, Building 1
Camden, South Carolina 29020

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 High-Dollar Payments for Outpatient Services Processed by Palmetto GBA, Intermediary #380, for the Period January 1, 2004, Through December 31, 2005." 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-04-08-06009 in all correspondence.

Sincerely,

John J. Drake, Jr. for

Peter J. Barbera
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, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR OUTPATIENT SERVICES PROCESSED BY PALMETTO GBA, INTERMEDIARY #380, FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

September 2008
A-04-08-06009

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 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, which administers the program, contracts with fiscal intermediaries to process and pay Medicare Part A claims submitted by hospitals. The intermediaries use the Fiscal Intermediary Standard System and the Centers for Medicare & Medicaid Services' Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

During our audit period (calendar years (CY) 2004 and 2005), Palmetto GBA (Palmetto) was the fiscal intermediary in South Carolina. Palmetto processed 12 outpatient claims totaling $846,832 during this period that had a payment of $50,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that Palmetto made to hospitals for outpatient services were appropriate.

SUMMARY OF FINDINGS

Of the 12 high-dollar payments that Palmetto made for outpatient services for CYs 2004 and 2005, 6 were appropriate. The remaining six payments included overpayments totaling $275,977.

Contrary to Federal guidance, hospitals inaccurately reported units of service. The hospitals attributed the incorrect claims to clerical errors or pharmacy systems with calculation errors in the billing template.

Palmetto made the overpayments because it did not have prepayment or postpayment controls to identify aberrant payments at the claim level. In addition, neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during CYs 2004 and 2005 to detect and prevent excessive payments.

RECOMMENDATION

We recommend that Palmetto recover the $275,977 in identified overpayments.

PALMETTO GBA COMMENTS

In written comments on our draft report, Palmetto agreed to recover the $275,977 in overpayments. The complete text of Palmetto's comments is included as the Appendix.

TABLE OF CONTENTS

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 Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part A claims submitted by hospital outpatient departments. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

To process hospitals' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validations.

In calendar years (CY) 2004 and 2005, fiscal intermediaries processed and paid approximately 278 million outpatient claims, 989 of which resulted in payments of $50,000 or more (high-dollar payments).

Claims for Outpatient Services

Medicare guidance requires hospitals to submit accurate claims for outpatient services. Hospitals should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed.

Palmetto GBA

During CYs 2004 and 2005, Palmetto GBA (Palmetto) was the fiscal intermediary in South Carolina. Palmetto processed 12 outpatient claims totaling $846,832 during this period that had a payment of $50,000 or more (high-dollar payments).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that Palmetto made to hospitals for outpatient services were appropriate.

Scope

We reviewed the 12 high-dollar payments for outpatient claims that Palmetto processed during CYs 2004 and 2005. We limited our review of Palmetto's internal control structure to those controls applicable to the 12 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 a reasonable assurance regarding 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 July 2007 through May 2008. Our fieldwork included contacting Palmetto, located in Columbia, South Carolina, and the hospitals that received high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify Medicare Part A outpatient claims with high-dollar payments;
- reviewed available CWF claims histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by a revised claim or whether the payments remained outstanding at the time of our fieldwork;
- contacted the hospitals that received the high-dollar payments to determine whether the information on the claims was correct and, if not, why the claims were incorrect and whether the hospitals agreed that refunds were appropriate; and
- confirmed with Palmetto that partial 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

Of the 12 high-dollar payments that Palmetto made for outpatient services for CYs 2004 and 2005, 6 were appropriate. The remaining six payments included overpayments totaling $275,977.

Contrary to Federal guidance, hospitals inaccurately reported units of service. The hospitals attributed the incorrect claims to clerical errors or pharmacy systems with calculation errors in the billing template.

Palmetto made the overpayments because it did not have prepayment or postpayment controls to identify aberrant payments at the claim level. In addition, neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during CYs 2004 and 2005 to detect and prevent excessive payments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states: "The definition of services units . . . is the number of times the service or procedure being reported was performed." In addition, chapter 1, section 80.3.2.2, of this manual states: "In order to be paid correctly and promptly, a bill must be completed accurately."

Section 3700 of the "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Palmetto made six overpayments totaling $275,977 on claims hospitals submitted with incorrect units of service. Hospitals attributed the incorrect claims to clerical errors or to pharmacy and billing systems that could not detect and prevent the incorrect billing of units of service.

CAUSES OF OVERPAYMENTS

During CYs 2004 and 2005, Palmetto did not have prepayment or postpayment controls to identify aberrant payments at the claim level, and the CWF lacked prepayment edits to detect and prevent excessive payments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[1]

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[1]The fiscal intermediary sends an "Explanation of Medicare Benefits" notice to the beneficiary after the hospital files a claim for Part A service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

FISCAL INTERMEDIARY PREPAYMENT EDIT

On January 3, 2006, after our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. The edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

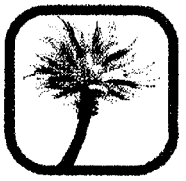
RECOMMENDATION

We recommend that Palmetto recover the $275,977 in identified overpayments.

PALMETTO GBA COMMENTS

In its August 5, 2008 written comments on our draft report, Palmetto agreed to recover the $275,977 in overpayments. The complete text of Palmetto's comments is included as the Appendix.

APPENDIX



Palmetto GBA
PARTNERS IN EXCELLENCE

Bruce W. Hughes
President and Chief Operating Officer

August 5, 2008

Mr. Peter J. Barbera
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of Inspector General
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Reference: Draft Report No. A-04-08-06009

Dear Mr. Barbera:

This letter is in response to the recent Office of Inspector General (OIG) draft report entitled "Review of High-Dollar Payments for Outpatient Services Processed by Palmetto GBA, Intermediary #380, for the Period January 1, 2004, Through December 31, 2005." We appreciate the feedback that your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

As stated in the draft report, overall it was found that six of the twelve outpatient claims reviewed resulted in overpayments totaling $275,977. It was determined that the hospitals inaccurately reported units of service. The hospitals attributed the incorrect claims to clerical errors or pharmacy systems with calculation errors in the billing template. At the time, Palmetto GBA made the overpayments because it did not have prepayment or postpayment controls to identify aberrant payments at the claim level. In addition, neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during calendar years 2004 and 2005 to detect and prevent excessive payments.

In December 2005, Palmetto GBA implemented a prepayment FISS edit to identify aberrant payments at the claim level with a threshold of $50,000 and an effective date of January 1, 2006. We continue to explore opportunities to expand and implement additional prepayment edits to mitigate excessive payments. In addition, we maintain a consistent approach in our provider education focusing on accurate billing. Our efforts have been very successful as demonstrated in the most recent Part A CERT scores for Palmetto GBA.

Palmetto GBA will adhere to the recommendations set forth by the OIG review to recover the $275,977 in identified overpayments. Once Palmetto GBA receives verification of the six claims from OIG, a notification will be sent to all providers informing them of the anticipated adjustment. We anticipate timely completion of all adjustments upon receipt.

Thank you for providing Palmetto GBA with the opportunity to provide feedback regarding your review. If you have any questions, please do not hesitate to contact me at 803-763-7130.

Sincerely,

Bruce W. Hughes

cc: Sandra Brown, Atlanta Regional Office, CMS
John Delaney, Dallas Regional Office, CMS