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

REGION V
OFFICE OF
INSPECTOR GENERAL

August 19, 2008

Report Number: A-05-08-00039

Ms. Pamela F. Bell
Staff Vice President, FGS/GA Medicare
Blue Cross and Blue Shield of Georgia, Inc.
3350 Peachtree Road NE
Atlanta, Georgia 30326

Dear Ms. Bell:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Blue Cross and Blue Shield of Georgia Medicare Payments to Providers Terminated From January 1, 2003, Through 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.

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 David Markulin, Audit Manager, at (312) 353-1644 or through e-mail at David.Markulin@oig.hhs.gov. Please refer to report number A-05-08-00039 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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
rokcmora@cms.hhs.gov

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF BLUE CROSS AND BLUE SHIELD OF GEORGIA MEDICARE PAYMENTS TO PROVIDERS TERMINATED FROM JANUARY 1, 2003, THROUGH JANUARY 31, 2007

Daniel R. Levinson
Inspector General

August 2008
A-05-08-00039

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 (CMS), which administers the program, contracts with fiscal intermediaries (FI) to process and pay Medicare claims submitted by health care providers.

The FIs must comply with Medicare regulations and policies, including those related to processing payments to terminated Medicare providers. The Medicare Intermediary Manual, section 3700, requires FIs to maintain adequate internal controls to prevent increased program costs and erroneous payments. 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 therefore under section 1866 [which sets forth the requirements for provider agreements] . . . ." Pursuant to the Medicare Financial Management Manual, Chapter 3, section 10.2, "An individual overpayment is an incorrect payment for provider or physician services made under title XVIII. Examples . . . are . . . payment for items or services rendered during a period of non-entitlement [e.g. periods for which a provider agreement was not in effect]." Section 20.2 states that "If the FI discovers an overpayment . . ., with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund . . . ."

Blue Cross and Blue Shield of Georgia, Inc. (Blue Cross), a FI, provides a broad range of services including claims processing and payment, customer service, and provider education and outreach. For our audit period January 1, 2003, through January 31, 2007, CMS terminated 102 providers serviced by Blue Cross.

OBJECTIVE

Our objective was to determine whether Blue Cross made unallowable payments for services that were furnished on or after the dates that the providers were terminated from the Medicare program.

SUMMARY OF FINDINGS

Prior to our audit, Blue Cross had not recovered $14,208 in unallowable payments made to 2 providers for 35 claims that were not eligible for payment because the services were provided on or after the dates that the providers were terminated from the Medicare program. Blue Cross made the unallowable payments because it received the claims prior to receiving the CMS termination notices. Blue Cross had not recovered the payments prior to our audit because it was unaware that one provider had been terminated from the Medicare program and because it received conflicting termination guidance from CMS for the other provider. Blue Cross confirmed that the payments were unallowable and subject to recovery.

RECOMMENDATION

We recommend that Blue Cross recover $14,208 in unallowable payments made to the two terminated Medicare providers.

BLUE CROSS COMMENTS

In written comments to our draft report, Blue Cross agreed with the finding and indicated that it recovered the unallowable payments made to the terminated Medicare providers. Blue Cross's comments are included in their entirety as the Appendix.

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BLUE CROSS COMMENTS

INTRODUCTION

BACKGROUND

Medicare Program

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), which administers the program, contracts with fiscal intermediaries (FIs) to process and pay Medicare claims submitted by health care providers. Pursuant to sections 1814(a) and 1866 of the Act, Medicare reimbursement is generally limited to participating providers that have entered into and maintain provider agreements, which set forth the terms and conditions for participation in the Medicare program. Terminated providers generally can not continue to participate in the Medicare program after their effective termination dates.

Medicare Payment Requirements

The Medicare Intermediary Manual, section 3700, requires FIs to maintain adequate internal controls to prevent increased program costs and erroneous payments. 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 therefore under section 1866 [which sets forth the requirements for provider agreements] . . . ." Pursuant to the Medicare Financial Management Manual, Chapter 3, section 10.2, "An individual overpayment is an incorrect payment for provider or physician services made under title XVIII. Examples . . . are . . . payment for items or services rendered during a period of non-entitlement [e.g. periods for which a provider agreement was not in effect]." Section 20.2 states that "If the FI discovers an overpayment . . ., with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund . . . ."

Blue Cross and Blue Shield of Georgia, Inc.

Blue Cross and Blue Shield of Georgia, Inc. (Blue Cross), a FI, provides a broad range of services including claims processing and payment, customer service, and provider education and outreach. For our audit period January 1, 2003, through January 31, 2007, CMS terminated 102 providers serviced by Blue Cross.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Blue Cross made unallowable payments for services that were furnished on or after the dates that the providers were terminated from the Medicare program.

Scope

We reviewed all Blue Cross payments for services provided by five providers[1] after CMS terminated them from the Medicare program during the period from January 1, 2003, through January 31, 2007. We limited our review of internal controls to discussing the procedures used to retroactively identify and recover unallowable payments to terminated Medicare providers.

We performed our fieldwork from November 2007 through May 2008.

Methodology

To accomplish the objective we:

- obtained a CMS nationwide list of 4,647 Medicare providers that were terminated on dates during the review period,
- queried the National Claims History File to identify potentially unallowable Medicare payments made by Blue Cross to terminated providers for services that were provided on or after the providers' effective termination dates, and
- identified providers that each received $5,000 or more in potentially unallowable payments and obtained additional information from Blue Cross and CMS to
  - determine whether the payments were unallowable and subject to recovery and
  - quantify the unallowable payments.

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 RECOMMENDATION

Prior to our audit, Blue Cross had not recovered $14,208 in unallowable payments made to 2 providers for 35 claims that were not eligible for payment because the services were provided on or after the dates that the providers were terminated from the Medicare program. Blue Cross made the unallowable payments because it received the claims prior to receiving the CMS termination notices. Blue Cross had not recovered the payments prior to our audit because it was unaware that one provider had been terminated from the Medicare program and because it received conflicting termination guidance from CMS for the other provider. Blue Cross confirmed that the payments were unallowable and subject to recovery.

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[1]Blue Cross and CMS provided information indicating that two providers had not received payments for services provided after their effective termination dates. For a third provider, we identified immaterial unallowable payments for services provided after the effective termination date.

MEDICARE PAYMENTS TO TERMINATED PROVIDERS

Prior to our review, Blue Cross had not recovered $14,208 paid to 2 providers for 35 claims that were not eligible for payment because the services were provided on or after the effective date that the providers were terminated from the Medicare program.

Federal Requirements

Pursuant to sections 1814(a) and 1866 of the Act, Medicare reimbursement is generally limited to participating providers that have entered into and maintain provider agreements, which set forth the terms and conditions for participation in the Medicare program. 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 therefore under section 1866 . . . ."

Section 3700 of the Medicare Intermediary Manual requires FIs to maintain adequate internal controls to prevent increased program costs and erroneous payments. Pursuant to the Medicare Financial Management Manual, Chapter 3, section 10.2, "An individual overpayment is an incorrect payment for provider or physician services made under title XVIII. Examples . . . are . . . payment for items or services rendered during a period of non-entitlement [e.g. periods for which a provider agreement was not in effect]." Section 20.2 states that "If the FI discovers an overpayment . . ., with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund . . . ."

Unallowable Payments Not Recovered

Two providers received unallowable Medicare payments for services that were performed on or after the effective dates that the providers were terminated from the Medicare program.

Table: Unallowable Claims and Payments

	Unallowable Claims	Unallowable Payments
Provider A	10	$7,814
Provider B	25	6,394
Totals	**35**	**$14,208**

Blue Cross had not recovered the unallowable payments prior to our audit. Blue Cross was not aware that CMS terminated provider A from the Medicare program and did not have a copy of the CMS termination notice. CMS terminated provider B upon the provider's request to withdraw from the Medicare program. All of the unallowable payments to provider B were for services provided on dates that preceded the date of the CMS termination notice.[2]

Blue Cross had not recovered the payments prior to our audit because it was unaware that provider A had been terminated from the Medicare program and because it received conflicting termination guidance from CMS for provider B.

[2]The CMS termination notice was dated about 16 months after the effective termination date.

RECOMMENDATION

We recommend that Blue Cross recover $14,208 in unallowable payments made to the two terminated Medicare providers.

BLUE CROSS COMMENTS

In written comments to our draft report, Blue Cross agreed with the finding and indicated that it recovered the unallowable payments made to the terminated Medicare providers. Blue Cross's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX

MEDICARE PART A INTERMEDIARY
Beneficiary Customer Service
1-800-MEDICARE (1-800-633-4227)
Provider Customer Service (877) 567-3095

July 28, 2008

Mr. Marc Gustafson, Regional Inspector General
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
233 North Michigan Avenue, Suite 1360
Chicago, Illinois 60601

RE: Report Number: A-05-08-00039

Dear Mr. Gustafson:

I am writing to provide comments related to the U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report. The report is entitled "Review of Blue Cross and Blue Shield of Georgia Medicare Payments to Providers Terminated from January 1, 2003 Through January 31, 2007". The report number is A-05-08-00039.

We appreciate the opportunity to make comments on the review summary. As a result of this review, we have been able to implement stronger controls in our own shop and look forward to additional changes that may occur as a result of your review, in the overall process of communicating provider terminations.

Blue Cross and Blue Shield of Georgia (BCBSGA) acknowledge the fact that there were incorrect payments made to the noted providers after termination. We are pleased to report that during the audit, BCBSGA recovered payments from Provider A totaling $7,814.05, Provider B totaling $6,394.02, and the third provider totaling $456.39.

As recommended, BCBSGA has recovered all unallowable payments as referenced in A-05-08-00039.

If you have any questions, please contact Karen Duck at (706) 571-5351 or by e-mail at kduck@bcbsga.com.

Sincerely,

Pamela F. Bell
Staff Vice President – FGS/GA Medicare