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-04-07-06025

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 Medicare Part B Claims Processed by Palmetto GBA, Carrier #880, for the Period January 1, 2004, Through December 31, 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 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-04-07-06025 in all correspondence.

Sincerely,

John J. Duke, Sr. /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 MEDICARE PART B CLAIMS PROCESSED BY PALMETTO GBA, CARRIER #880, FOR THE PERIOD JANUARY 1, 2004, THROUGH DECEMBER 31, 2006

Daniel R. Levinson
Inspector General

September 2008
A-04-07-06025

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 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 providers in South Carolina. During calendar years 2004–2006, Palmetto processed claims for 12,750 Part B providers; 371 claims resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Palmetto's high-dollar Medicare payments to Part B providers were appropriate.

SUMMARY OF FINDING

Of the 371 high-dollar payments that Palmetto paid to providers, 355 were appropriate. Palmetto overpaid 16 providers $33,953 for the remaining claims.

The providers attributed the incorrect claims to clerical errors. In addition, Palmetto made the overpayment because providers incorrectly submitted claims and the Medicare claim processing systems did not have sufficient edits in place during calendar years 2004–2006 to detect and prevent payments for these types of erroneous claims. However, in January 2007, Palmetto implemented CMS-required units-of-service edits referred to as "medically unlikely" edits to suspend potentially excessive Medicare payments for prepayment review.

RECOMMENDATION

We recommend that Palmetto recover the $33,953 in overpayments.

PALMETTO GBA COMMENTS

In its written comments on our draft report, Palmetto agreed to recover the $33,953 in overpayments. The complete text of Palmetto's comments is included 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 (CWF). 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) 2003–2005, providers nationwide submitted approximately 2.3 billion claims to carriers. Of these, 29,022 claims resulted in payments of $10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

Palmetto GBA

Palmetto GBA (Palmetto) is the Medicare Part B carrier for providers in South Carolina. During calendar years (CY) 2004–2006, Palmetto processed claims for 12,750 Part B providers; 371 claims resulted in payments of $10,000 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.

[1]The 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, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Palmetto's high-dollar Medicare payments to Part B providers were appropriate.

Scope

We reviewed the 371 high-dollar payments totaling $4,454,224 that Palmetto processed during CYs 2004–2006. We limited our review of Palmetto's internal controls to those applicable to the 371 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 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 performed our fieldwork from October 2007 through May 2008. Our fieldwork included contacting Palmetto, located in Columbia, South Carolina, and the providers that received high-dollar payments.

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 payments;
- reviewed available CWF claim histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;
- analyzed CWF data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and
- coordinated our claim review, including the calculation of any overpayments, with Palmetto.

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.

FINDING AND RECOMMENDATION

Of the 371 high-dollar payments that Palmetto paid to providers, 355 were appropriate. Palmetto overpaid providers $33,953 for the remaining 16 claims.

The providers attributed the incorrect claims to clerical errors. In addition, Palmetto made the overpayment because providers incorrectly submitted claims and the Medicare claim processing systems did not have sufficient edits in place during CYs 2004–2006 to detect and prevent payments for these types of erroneous claims. However, in January 2007, Palmetto implemented CMS-required units-of-service edits referred to as "medically unlikely" edits to suspend potentially excessive Medicare payments for prepayment review.

MEDICARE 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 overpayments totaling $33,953 for 16 high-dollar claims:

- For two claims, the providers stated that they billed incorrectly because at the time they did not know whether Medicare was the primary insurer or not. The refund is due to Medicare because it was not the primary insurer. As a result, Palmetto overpaid the providers $21,331.

- For eight claims, the providers stated that they billed incorrect units of service due to clerical errors. As a result, Palmetto overpaid the providers $11,332.

- For six claims, the providers stated that they billed incorrect procedure codes due to clerical errors. As a result, Palmetto overpaid the providers $1,290.

CAUSES OF INCORRECT PAYMENTS

The providers attributed the incorrect claims to clerical errors. In addition, during CYs 2004–2006, the Medicare Multi-Carrier Claims System and the CMS CWF 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] However, in January 2007, Palmetto implemented CMS-required units-of-service edits referred to as "medically unlikely" edits to suspend potentially excessive Medicare payments for prepayment review.

RECOMMENDATION

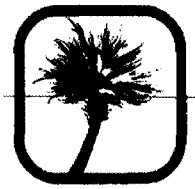
We recommend that Palmetto recover the $33,953 in overpayments.

PALMETTO GBA COMMENTS

In its July 18, 2008 written comments on our draft report, Palmetto stated that it had initiated recovery of the $33,953 in overpayments. The complete text of Palmetto's comments is included as the Appendix.

[2]The 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



Palmetto GBA.
PARTNERS IN EXCELLENCE℠

Bruce W. Hughes
President and Chief Operating Officer

July 18, 2008

Peter J. Barbera
Regional Inspector General for Audit Services
Office of Inspector General, Region IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Dear Mr. Barbera:

This is in response to your letter dated June 17, 2008, conveying your draft report entitled "Review of High-Dollar Payments for Medicare Part B Claims Processed by Palmetto GBA, Carrier #880, for the Period January 1, 2004, through December 31, 2006." In your letter, you requested that Palmetto GBA provide written comments and a status of any action taken on your recommendations.

The attached draft report indicated that your objective was to determine whether Palmetto GBA's high-dollar Medicare payments to Part B providers were appropriate. Based on a review of our high-dollar payments, you determined that of the 371 high-dollar payments that Palmetto made to providers, 355 were appropriate. You further determined that Palmetto GBA's erroneous overpayments occurred because the providers filed their claims incorrectly and the Medicare claims processing system did not have sufficient edits in place, during the time reviewed, to detect the defined errors and prevent overpayments.

Pursuant to your recommendation, Palmetto GBA obtained copies of the providers' responses to the OIG's request for information. Palmetto GBA agrees that based on the provider's comments, overpayments were inadvertently made because incorrect claim information was submitted. Therefore, the appropriate recoupment activities have been initiated to recover the $33,953.00 in identified overpayments and Palmetto GBA will follow through until all overpayments are recovered.

Should you have questions or require additional information, please do not hesitate to contact me at either 803-763-7130 or bruce.hughes@palmettogba.com.

Sincerely,

Bruce W. Hughes