Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

February 21, 2008

Report Number: A-02-07-01041

Ms. Gloria Lebron
Vice-President, Medicare
Triple-S, Inc.
P.O. Box 71391
San Juan, Puerto Rico 00936-1391

Dear Ms. Lebron:

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 Triple-S, Inc., for the Period January 1, 2003, 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 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, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please contact Brenda Ryan, Audit Manager, at (212) 246-4677 or through e-mail at Brenda.Ryan@oig.hhs.gov. Please refer to report number A-02-07-01041 in all correspondence.

Sincerely,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Tom Lenz, 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 TRIPLE-S, INC., FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

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Office of Inspector General

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Department of Health and Human Services

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In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS 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 persons 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.

Triple-S, Inc. (Triple-S) is the Medicare Part B carrier for about 8,200 providers in Puerto Rico and the U.S. Virgin Islands. During calendar years (CY) 2003-2005, Triple-S processed more than 24 million Part B claims, 13 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

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

SUMMARY OF FINDING

Three of the thirteen high-dollar payments that Triple-S made to providers were appropriate. However, for the 10 remaining payments, Triple-S overpaid providers $45,426 for four payments and CMS's Program Safeguard Contractor was reviewing six payments. Providers refunded two of the four overpayments, totaling $32,445, prior to our fieldwork. Two overpayments, totaling $12,981, remained outstanding.

Triple-S made the overpayments because three providers incorrectly claimed excessive units of service, and the carrier inaccurately entered the payment rate for one claim. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003-2005 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that Triple-S:

- recover the $12,981 overpayment and

- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005.

TRIPLE-S, INC.'S COMMENTS

In its written comments on our draft report, Triple-S agreed with our first recommendation. Regarding our second recommendation, Triple-S stated that it implemented a computer edit on May 16, 2007, to identify and help recover potential high-dollar overpayments. However, Triple-S's action did not address any potential high-dollar overpayments made between January 1, 2006, and May 15, 2007. Triple-S's comments are included in their entirety 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. 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.

Triple-S, Inc.

Triple-S, Inc. (Triple-S) is the Medicare Part B carrier for about 8,200 providers in Puerto Rico and the U.S. Virgin Islands. Triple-S used the Viable Information Processing System (VIPS) Medicare System to process claims until July 31, 2005, and began processing new claims using the Medicare Multi-Carrier Claims System in August 2005.[2] During CYs 2003– 2005, Triple-S processed more than 24 million Part B claims, 13 of which resulted in 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,

[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.

[2]CMS required carriers to transition to the Medicare Multi-Carrier Claims System beginning in 2002. Before that time, carriers could use either the VIPS Medicare System or the Medicare Multi-Carrier Claims System.

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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed seven of the 13 high-dollar payments, totaling $98,384, that Triple-S processed during CYs 2003-2005. We did not review six payments, totaling $70,643, due to an ongoing review by CMS's Program Safeguard Contractor.

We limited our review of Triple-S's internal controls to those applicable to the 13 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 at Triple-S in San Juan, Puerto Rico, from April to June 2007.

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 Common Working File 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 Common Working File 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 Triple-S.

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 RECOMMENDATIONS

Three of the thirteen high-dollar payments that Triple-S made to providers were appropriate. However, for the remaining 10 payments, Triple-S overpaid providers $45,426 for four payments. and CMS's Program Safeguard Contractor was reviewing six payments. Providers refunded two of the four overpayments, totaling $32,445, prior to our fieldwork. Two overpayments, totaling $12,981, remained outstanding.

Triple-S made the overpayments because three providers incorrectly claimed excessive units of service, and the carrier inaccurately entered the payment rate in one instance. In addition, the Medicare claims processing systems did not have sufficient edits in place during CYs 2003-2005 to detect and prevent payments for these types of erroneous claims.

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

For three of the four overpayments, totaling $29,426, providers incorrectly billed Triple-S for excessive units of service:

- One provider billed 400 units of service (doses of a chemotherapy drug) for 40 units delivered. The provider stated that it had miscalculated the doses administered. As a result, Triple-S paid the provider $18,272 when it should have paid $1,827, an overpayment of $16,445. The provider identified and refunded the overpayment prior to our fieldwork.

- One provider billed 50 units of service (doses of a chemotherapy drug) for five units delivered. The provider stated that it had miscalculated the doses administered. As a result, Triple-S paid the provider $14,254 when it should have paid $1,436, an overpayment of $12,818. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

- One provider billed three units of service (subsequent hospital care) for five units delivered, and 77 units of service (critical care) for 75 units delivered. The provider

stated that it had miscalculated the time spent by the physician with the patient. As a result, Triple-S paid the provider $10,322 when it should have paid $10,159, a net overpayment of $163. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

For the fourth overpayment, the carrier entered a payment rate of $20,257.37 instead of $257.37 for eye surgery. The carrier stated that it had processed the claim manually, since the VIPS Medicare System lacked a price code for this service, and mistakenly entered the payment rate. As a result, Triple-S paid the provider $16,206 when it should have paid $206, an overpayment of $16,000. The provider identified and refunded the overpayment prior to our fieldwork.

Providers attributed the incorrect claims to clerical errors made by their billing staffs, and the carrier attributed its incorrect claim to a clerical error made by its claims examiner. In addition, during CYs 2003–2005, the VIPS Medicare System, the Medicare Multi-Carrier Claims System, and the CMS Common Working File did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service and payment rates. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[3]

RECOMMENDATIONS

We recommend that Triple-S:

- recover the $12,981 overpayment and

- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2005.

TRIPLE-S, INC.'S COMMENTS

In its January 30, 2008, written comments on our draft report, Triple-S agreed with our first recommendation. Regarding our second recommendation, Triple-S stated that it implemented a computer edit on May 16, 2007, to identify and help recover potential high-dollar overpayments. However, Triple-S's action did not address any potential high-dollar overpayments made between January 1, 2006, and May 15, 2007. Triple-S's comments are included in their entirety as the Appendix.

[3]The carrier sends an "Explanation of Medicare Benefits" 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

MEDICARE
Part-B Carrier
Bene. PR & USVI 1-800-MEDICARE (1-800-633-4227)
Prov. PR & USVI 1-877-715-1921
TTY/TDD - 1-877-486-2048

VP-2008-008

January 30, 2008

Mr. James P. Edert
Regional Inspector General for Audit Services
DHHS, OIG/OAS
26 Federal Plaza, Room 3900
New York, NY 10278

Ref: Report Number A-02-07-01041

Dear Mr. Edert:

This is in response to your letter dated January 2, 2008, regarding the Office of Inspector General Office of Audit Services draft report entitled "***Review of High-Dollar Payments for Medicare Part B Claims Processed by Triple-S, Inc. for the Period January 1, 2003 through December 31, 2005***".

The following is this Carrier's course of action taken as it relates to the recommendations presented in the OIG Auditors' report.

1. Of the two (2) remaining overpayments totaling $12,981, Triple-S recouped one (1) overpayment totaling $471 which was the result of reviewing and adjusting the claim to reflect the final overpayment due. The remaining overpayment of $12,818 continues outstanding; however, Triple-S had not recouped the monies because although the recoupment process was initiated during the OIG audit, the forty-five (45) days to execute the offset was schedule for the third week in January. Therefore, at the time of this response, Triple-S has begun withholding payments to the provider in order to fully recoup the overpayment.

2. In order to immediately address the issues identified, Triple-S installed edit 366D on May 16, 2007 which suspends every single claim that is billed with a submitted charged greater than $10,000. These claims are not process until they are analyzed by the Claims supervisor to ensure that the claim has been billed correctly by the provider.

3. To apply additional safeguards against unnecessary utilization of services, a managerial oversight of a system generated report containing claims paid over $10,000 is conducted on quarterly basis to ensure compliance with CMS requirements. To this date, the results of these reviews have demonstrated that the providers are billing accurately by reporting the correct number of units of service as the number of times that a service or procedure is required. Therefore, the claims greater than $10,000 are being process in accordance with the instructions stipulated by the 366D edit and being paid correctly.

Should you have any questions regarding this response or need further information, please to do not hesitate in contacting me at (787) 749-4083.

Cordially,

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