



DEPARTMENT OF HEALTH & HUMAN SERVICES  
OFFICE OF INSPECTOR GENERAL  
OFFICE OF AUDIT SERVICES  
150 S. INDEPENDENCE MALL WEST  
SUITE 316  
PHILADELPHIA, PENNSYLVANIA 19106-3499

**JUN 22 2004**

Report Number: A-03-04-00013

Ms. Elizabeth A. Farbacher  
Senior Vice President and Chief Audit Executive  
Highmark  
120 Fifth Avenue, Suite 3116  
Pittsburgh, Pennsylvania 15222-3099

Dear Ms. Farbacher:

Enclosed are two copies of the U.S. Department of Health and Human Services Office of Inspector General's report entitled "Audit of Keystone Health Plan West Medicare+Choice Payments to Noncontracted Providers" for the period August 1, 2003 through January 31, 2004.

In accordance with the principles of the Freedom of Information Act (5 USC 552, as amended by Public Law 104-231), Office of Inspector General reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5).

Should you have any questions or comments concerning the matters commented on in this report, please do not hesitate to call me at (215) 861-4470, or James Maiorano, Audit Manager, at (215) 861-4476, or contact me or Mr. Maiorano at the above address. To facilitate identification, please refer to report number A-03-04-00013 in all correspondence.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Stephen Virbitsky", with a long horizontal flourish extending to the right.

Stephen Virbitsky  
Regional Inspector General  
for Audit Services

Enclosures

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**AUDIT OF  
KEYSTONE HEALTH PLAN WEST  
MEDICARE+CHOICE PROGRAM  
PAYMENTS TO  
NONCONTRACTED PROVIDERS**



**JUNE 2004  
A-03-04-00013**

# ***Office of Inspector General***

**<http://oig.hhs.gov>**

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The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

## ***Office of Evaluation and Inspections***

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

## ***Office of Investigations***

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees state Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

# *Notices*

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**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <http://oig.hhs.gov>

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**

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the Medicare+Choice (M+C) program. The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with the Centers for Medicare & Medicaid Services (CMS). These plans provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers. Federal regulations at 42 CFR 422 require plans to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers.

### **OBJECTIVE**

Our objective was to determine whether Keystone Health Plan West (Keystone) complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

### **SUMMARY OF FINDINGS**

Keystone complied with Federal prompt payment regulations to timely pay or deny claims submitted by noncontracted providers. Specifically, it (1) paid at least 95 percent of clean claims<sup>1</sup> within 30 days of receipt, (2) paid interest on clean claims not paid within 30 days of receipt, and (3) paid or denied claims within 60 days of receipt.

### **RECOMMENDATIONS**

We have no recommendations to make at this time.

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<sup>1</sup> A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

## **INTRODUCTION**

### **BACKGROUND**

#### **The Medicare+Choice Program**

The Balanced Budget Act of 1997 amended Title XVIII of the Social Security Act to establish the M+C program<sup>2</sup>. The program provides Medicare beneficiaries the option of obtaining their Medicare health coverage from private health plans under contract with CMS. These plans, known as M+C organizations, are required to provide enrollees with the same health care services offered under the traditional Medicare program plus additional benefits<sup>3</sup>. These organizations provide services directly to beneficiaries, through arrangements with contracted providers, or by purchasing services from noncontracted providers<sup>4</sup>. Claims for services are processed by the M+C organization or through agreements with delegated entities<sup>5</sup>.

#### **Keystone Health Plan West**

Keystone is a health maintenance organization serving Western Pennsylvania. CMS contracted with Keystone as an M+C organization to provide health care coverage to approximately 181,000 Medicare enrollees in Western Pennsylvania during our audit period.

#### **CMS Reviews**

CMS conducts a detailed review of each M+C organization at least once every 2 years. The reviews include internal control and substantive tests of an M+C organization's claims processing systems and compliance with prompt payment provisions. CMS reviewed Keystone's claims processing in May 2000 and May 2002 and found it did not comply with prompt payment regulations. These reviews disclosed that Keystone paid less than 95 percent of all clean claims within the required 30 days.

### **OBJECTIVE, SCOPE, AND METHODOLOGY**

#### **Objective**

Our objective was to determine whether Keystone complied with M+C prompt payment regulations to timely pay or deny claims submitted by noncontracted providers.

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<sup>2</sup> The Medicare+Choice program will be replaced by the Medicare Advantage Program under the Medicare Prescription Drug, Improvement and Modernization Act of 2003, effective January 1, 2006.

<sup>3</sup> Additional benefits are health care services not covered by Medicare and reductions in premiums or cost sharing for Medicare-covered services.

<sup>4</sup> A noncontracted provider does not have a written agreement with an M+C organization to provide services to an M+C organization's enrollees.

<sup>5</sup> A delegated entity is contracted by an M+C organization to provide administrative or health care services to Medicare-eligible individuals enrolled in the M+C organization's service plan.

## **Scope**

We reviewed selected noncontracted Medicare claims paid or denied by Keystone during the period August 1, 2003 through January 31, 2004. Keystone paid or denied 70,943 claims for services furnished by noncontracted providers during the period. This is 3 percent of the total claims processed directly by Keystone during the audit period.

Because of the small number, we did not review any claims that resulted in payments to enrollees. Further, we did not review the M+C claims processed by Keystone's single delegated entity because the number of claims processed was not material. We limited our review of internal controls to obtaining an understanding of Keystone's claims processing system.

## **Methodology**

To accomplish our objective, we:

- reviewed Federal regulations, policies, and procedures relevant to the prompt payment of noncontracted claims
- consulted with CMS officials to understand CMS's implementation of the M+C program monitoring requirements and prompt payment regulations
- reconciled claims submitted by selected noncontracted providers to claims reported by Keystone

To determine whether Keystone complied with prompt payment regulations, we separately reviewed the populations of paid clean claims, paid unclean claims processed in 60 days or less, denied claims processed in 60 days or less, and claims that did not appear to have been paid or denied within 60 days of receipt. To identify the claims not paid or denied in less than 60 days, we compared the receipt dates and paid or denied dates recorded by Keystone. From each population, we selected and reviewed 30 or more claims.

Additionally, we verified that interest was properly paid. To do this, we selected clean claims that were not paid within 30 days of receipt, and reviewed the interest calculation and the amount paid to the provider. For each claim, we analyzed claims history records and other supporting documentation.

We conducted our fieldwork during March and April 2004, which included work at Keystone's office in Pittsburgh, Pennsylvania.

We performed our audit in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

Keystone complied with Federal prompt payment regulations to timely pay or deny claims submitted by noncontracted providers. Specifically, it (1) paid at least 95 percent of clean claims within 30 days of receipt, (2) calculated and paid interest on clean claims not paid within 30 days of receipt, and (3) paid or denied claims within 60 days of receipt.

### **FEDERAL REGULATIONS FOR PROMPT PAYMENT**

Federal regulations at 42 CFR § 422.100(b) require M+C organizations to make timely payment to, or on behalf of, plan enrollees for services obtained from noncontracted providers. The responsibilities for timely payment are clarified in 42 CFR § 422.520:

- (a)(1) ...the M+C organization will pay 95 percent of the “clean claims” within 30 days of receipt if they are submitted by, or on behalf of, an enrollee of an M+C private fee-for-service plan or are claims for services that are not furnished under a written agreement between the organization and the provider.
- (2) The M+C organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2)(B) and 1842(c)(2)(B). [Sections 1816 and 1842 refer to Title XVIII of the Social Security Act for Medicare fiscal intermediaries and carriers.]
- (3) All other claims must be paid or denied within 60 calendar days from the date of the request.

A clean claim does not have any defect, impropriety, lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment.

### **PAYMENT OF CLAIMS**

Keystone paid or denied claims in compliance with the 30 and 60 calendar day timeframes set by CMS. Keystone paid at least 95 percent of all clean claims within 30 days of receipt. We determined that during the audit period, Keystone paid over 99 percent of clean noncontracted provider claims within 30 days of receipt. Also, Keystone calculated and paid interest on clean claims that were not paid in 30 days.

### **RECOMMENDATIONS**

We have no recommendations to make at this time.