DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

SEP 10 2008

Report Number: A-03-07-00021

Mr. Bruce Hughes
President & Chief Operating Officer
Palmetto GBA
P. O. Box 100134
Columbia, South Carolina 29202

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 West Virginia Medicare Part B Claims Processed by Palmetto GBA 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, 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 at (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through e-mail at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-07-00021 in all correspondence.

Sincerely,

Bernard Siegel for

Stephen Virbitsky
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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR WEST VIRGINIA MEDICARE PART B CLAIMS PROCESSED BY PALMETTO GBA FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

September 2008
A-03-07-00021

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, a wholly owned subsidiary of BlueCross BlueShield of South Carolina, was the Medicare Part B carrier for West Virginia. During calendar years (CY) 2003–05, Palmetto GBA processed more than 16 million claims as the Part B carrier, 6 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Palmetto GBA's high-dollar payments as the Medicare Part B carrier for West Virginia were appropriate.

SUMMARY OF FINDING

One of six high-dollar payments Palmetto GBA made as the carrier for West Virginia was appropriate. However, Palmetto GBA overpaid providers $102,200 for five payments. Two providers refunded two of the overpayments totaling $36,492 prior to our audit and one provider refunded one overpayment totaling $9,096 as the result of our audit. Two overpayments totaling $56,612 remained outstanding from one provider.

Palmetto GBA made the overpayments because four providers incorrectly claimed excessive units of service on five claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–05 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that Palmetto GBA:

- recover the $56,612 in overpayments and

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

PALMETTO GBA COMMENTS

In comments on our audit report (appendix), Palmetto GBA concurred with the recommendations.

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 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) 2003–05, 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, a wholly owned subsidiary of BlueCross BlueShield of South Carolina, was the Medicare Part B carrier for West Virginia.[2] Palmetto GBA used the Medicare Multi-Carrier Claims System to process claims. During CYs 2003–05, Palmetto GBA processed more than 16 million claims as the Part B carrier, 6 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," Pub. No. 100-08, Transmittal 178, Change Request 5402, a "medically unlikely edit" tests claim lines for the same beneficiary, procedure 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, P.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]In addition to its headquarters in Columbia, South Carolina, Palmetto GBA has additional offices in 14 states.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Palmetto GBA's high-dollar payments as the Medicare Part B carrier for West Virginia were appropriate.

Scope

We reviewed the six high-dollar payments, totaling $118,698 that Palmetto GBA processed during CYs 2003–05. We limited our review of Palmetto GBA's internal controls to those applicable to the six 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.[3]

We conducted our audit from April through July 2008.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare Part B claims with high-dollar payments;
- reviewed available Common Working File data for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our audit;
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were for 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 GBA.

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

[3]When the Common Working File history was not available due to the age of the claim, we obtained a claim history from Palmetto GBA that contained comparable information.

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.

FINDINGS AND RECOMMENDATIONS

One of six high-dollar payments Palmetto GBA made as the carrier for West Virginia was appropriate. However, Palmetto GBA overpaid providers $102,200 for five payments. Two providers refunded two of the overpayments totaling $36,492 prior to our audit and one provider refunded one overpayment totaling $9,096 as the result of our audit. Two overpayments totaling $56,612 remained outstanding from one provider.

Palmetto GBA made the overpayments because four providers incorrectly claimed excessive units of service on five claims. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2003–05 to detect and prevent payments for these types of erroneous claims.

MEDICARE REQUIREMENTS

The CMS "Carriers Manual," Pub. No. 14, part 2, § 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 GBA overpaid providers $102,200 for five payments for which four providers incorrectly billed Palmetto GBA for excessive units of service.

- For two claims the provider billed 410 cardiac stress test imaging studies instead of 1 study per claim. As a result, Palmetto GBA paid the provider $56,750 for the two claims when it should have paid $138, an overpayment of $56,612. The provider had not refunded the overpayment at the time of our audit.

- For one claim the provider billed 125 computerized tomography scans instead of 1 scan. As a result, Palmetto GBA paid the provider $26,675 when it should have paid $213, an overpayment of $26,462. The provider refunded the overpayment prior to our audit.

- For two claims two providers billed six units of pegfilgrastim, used to reduce infection in chemotherapy patients, instead of one unit.

    - For one claim, Palmetto GBA paid the provider $12,036 when it should have paid $2,006, an overpayment of $10,030. The provider refunded the overpayment prior to our audit.

- For one claim, Palmetto GBA paid the provider $10,915, when it should have paid $1,819, an overpayment of $9,096. The provider refunded the overpayment as a result of our audit.

Providers attributed the incorrectly billed quantities and services to clerical errors made by their billing staffs.

INSUFFICIENT PREPAYMENT CONTROLS

During CYs 2003–05, Palmetto GBA, 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. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[4]

RECOMMENDATIONS

We recommend that Palmetto GBA:

- recover the $56,612 in overpayments and

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

PALMETTO GBA COMMENTS

In comments on our audit report, Palmetto GBA concurred with the recommendations and provided information on actions that it had already taken. Palmetto GBA's comments are included as the appendix.

[4]The carrier sends a "Medicare Summary Notice" to the beneficiary for each claim submitted by the provider for Part B services. The notice explains the services billed the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX

Palmetto GBA
PARTNERS IN EXCELLENCE

Gary Zapf,
Senior Director
OH/WV Medicare Operations

August 29, 2008

Stephen Virbitsky
Regional Inspector General for Audit Services
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA. 19106-3499

Dear Mr. Virbitsky:

This is in response to your letter dated July 29, 2008 detailing the draft report for the West Virginia Medicare Part B claims processed by Palmetto GBA for the period January 1, 2003 through December 31, 2005, report number: A-03-07-00021. The letter requested that Palmetto GBA provide written comments to include a statement of concurrence or non-concurrence with the recommendations.

The objective of the review of the high dollar payments for West Virginia was to determine whether Palmetto GBA payments were appropriate. Based upon your review of our high dollar payments, you determined that one of the six payments reviewed was appropriate. Palmetto GBA overpaid providers $102,200 on the remaining five claims. Two providers refunded two of the overpayments prior to the review totaling $36,492 and one provider refunded one overpayment totaling $9,096 as the result of the audit. Two overpayments totaling $56,612 remained outstanding from one provider.

Based upon Palmetto GBA's review of the claims and information provided, Palmetto GBA concurs that the overpayments were the result of provider billing errors. The appropriate recoupment of the overpayments has been initiated and we will continue to follow up to ensure the refunds are received.

Additional editing to minimize inappropriate payments of high dollar claims was implemented in May, 2005. This edit suspends claims with a billed amount of $10,000 or more for manual review. Four of the five claims containing overpayments were submitted and processed prior to the implementation of the high dollar edit. The remaining claim suspended for review, however, due to human error was processed incorrectly. The claims analyst responsible has been provided the necessary feedback. Also, refresher training was conducted for all staff processing the high dollar edit claims in April 2008.

As part of Palmetto GBA's continuing efforts to improve our service, Palmetto GBA is also reviewing the effectiveness of the high dollar edit and considering limiting the handling of high dollar claims to the most experienced claims analysts to promote consistency and accuracy in the processing of the high dollar claims while strengthening the overall control of the process. We intend to review a number of high dollar claims containing dates of service after the implementation of the edit to determine if additional controls are needed to ensure the safeguards of program funds.

In addition to the high dollar edit mentioned above, the Medically Unlikely Edits (MUE) were implemented in accordance with the CMS directive in October 2007. Palmetto GBA is also working to implement Clinically Unlikely Edits (CUE) that will further enhance controls to detect quantity billed errors by initially establishing recommended dosages for drugs. The first of the CUE edits is expected to be implemented by October 1, 2008.

Please do not hesitate to contact me if you require additional information, 614-473-7117.

Sincerely,

Gary Zapf
Senior Director

CC: Bruce Hughes, President & COO