Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

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

October 2, 2003

Report Number: A-02-02-01019

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

Dear Ms. Lebrón:

The attached report provides the results of our self-initiated audit entitled "Review of Care Plan Oversight in Puerto Rico." A copy of this audit report will be forwarded to the action official noted below for his review and any action deemed necessary.

The objective of this review was to determine whether claims for care plan oversight (CPO) services rendered by physicians in Puerto Rico were paid in accordance with Medicare requirements. Our audit included a universe of 37,020 CPO claims representing $2,159,018 reimbursed by Medicare to physicians for services rendered during January 1, 1999 through December 31, 2000.

The Centers for Medicare & Medicaid Services' Medicare Carriers Manual Part 3, contains the billing requirements for CPO services rendered by physicians. CPO services are to be provided by physicians to beneficiaries that are receiving services by a home health agency or hospice under an approved plan of care. The Medicare coverage for this service became effective January 1, 1995.

We found a significant problem with physician claims to Medicare for reimbursement of CPO services in Puerto Rico. Physicians are billing for CPO services but are not adhering to the Medicare requirements that govern CPO services. Although physicians met a few of the general billing requirements, we found that, in all 30 claims tested, physicians did not maintain required supporting documentation in their medical records to establish that reimbursable CPO services had actually been provided and that their billings to Medicare were proper and justified. We believe the degree of noncompliance we encountered in our review and the unfamiliarity of physicians with Medicare billing requirements necessitates immediate action by Triple S.

In general, physicians that we interviewed were not aware of the requirements to bill Medicare for CPO services and some indicated that they did not understand the concept of reimbursement for CPO. Although Triple S had provided some educational outreach, it is apparent that a much greater effort is needed.

In our audit report, we recommended that Triple S

- Develop an action plan targeted towards providing educational outreach in order to promote full awareness of the CPO billing requirements among the physician community;

- Perform periodic post payment review of CPO claims submitted by physicians to ascertain that physicians are adhering to Medicare billing requirements; and

- Conduct additional reviews of claims by physicians with significant CPO billings to recover inappropriate payments that have been made.

Triple S has agreed to immediately address our recommendations. Triple S has indicated that it will increase provider education and perform a closer review of providers who are claiming CPO reimbursement. Triple S has also taken the initiative to begin recovery of the potential overpayments identified for the 30 claims discussed in our audit report.

The HHS action official named below will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act 5 U.S.C. 552, as amended by Public Law 104-231, OIG reports are made available to members of the public to the extent information contained therein is not subject to exemptions in the Act (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the word wide web at http://oig.hhs.gov.

To facilitate identification, please refer to Report Number A-02-02-01019 in all correspondence relating to this report.

Sincerely,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Dr. Gilbert Kunken
Acting Regional Administrator
Centers for Medicare & Medicaid Services
26 Federal Plaza, Room 3800
New York, NY 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE CARE PLAN OVERSIGHT IN PUERTO RICO

Inspector General
October 2003
A-02-02-01019

Office of Inspector General

http://oig.hhs.gov

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:

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EXECUTIVE SUMMARY

Background

The Centers for Medicare & Medicaid Services (CMS) has contracted the administration of the Medicare Part B program to carriers throughout the nation. Part B covers the physician services, including care plan oversight (CPO), and other health care providers not covered by Part A. Seguros de Servicios de Salud de Puerto Rico (Triple S) serves as the Medicare carrier for the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

CPO is the physician supervision of patients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies. Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the home health agency or hospice during the month for which CPO services were billed.

Objective

The objective of this review was to determine whether claims for CPO services rendered by physicians in Puerto Rico were paid in accordance with Medicare requirements.

Summary of Finding

There is a significant problem with physician claims to Medicare for reimbursement of CPO services in Puerto Rico. Physicians are billing for CPO services but are not adhering to the Medicare requirements that govern CPO services. Although physicians met a few of the general billing requirements, we found that, in all 30 claims tested, physicians did not maintain required supporting documentation in their medical records to establish that reimbursable CPO services had actually been provided and that their billings to Medicare were proper and justified.

In general, physicians that we interviewed were not aware of the requirements to bill Medicare for CPO services and some indicated that they did not understand the concept of reimbursement for CPO. We did learn that many believed they were entitled to bill Medicare just for signing the plan of care. However, their belief is entirely unfounded and inconsistent with Medicare requirements. Although Triple S had provided some educational outreach, it is apparent that a much greater effort is needed.

We used simple random sampling techniques to select a sample of 30 claims totaling $1,738 from the universe of 37,020 CPO claims representing $2,159,018 paid by Triple S. Our review of documentation maintained by physicians for the sample claims disclosed that there was not adequate support for the services billed and, therefore, did not meet CPO billing requirements.

Because we found all 30 claims in our random sample were in error, there is a significant risk that $2,159,018 for 37,020 claims was improperly reimbursed by the Medicare carrier to physicians for CPO services rendered during the period January 1, 1999 through December 31, 2000. These 37,020 claims were paid to 983 physicians with reimbursements ranging from a high of $50,771 to a low of $28. We believe the degree of noncompliance we encountered in our review and the unfamiliarity of physicians with Medicare billing requirements necessitates immediate action by Triple S.

Recommendations

We recommend that Triple S:

- Develop an action plan targeted towards providing educational outreach in order to promote full awareness of the CPO billing requirements among the physician community;

- Perform periodic post payment review of CPO claims submitted by physicians to ascertain that physicians are adhering to Medicare billing requirements; and

- Conduct additional reviews of claims by physicians with significant CPO billings to recover inappropriate payments that have been made.

Auditee Comments

In their comments, dated July 29, 2003 Triple S agreed to immediately address our recommendations. Triple S' corrective action plan includes increased provider education and closer review of providers who are claiming CPO reimbursement. Triple S has also taken the initiative to begin recovery of the potential overpayments identified for the 30 claims discussed in our draft report. Triple S' comments are included in their entirety as Appendix A to this report.

OIG Response

We are pleased to learn that Triple S not only accepts our recommendations, but has also begun implementing them. We are encouraged by Triple S' proactive efforts to recover the potential overpayments we identified. The OIG supports this initiative and is providing Triple S officials with the supporting documentation obtained during our audit.

GLOSSARY OF ABBREVIATIONS AND ACRONYMS

CMS	Centers for Medicare & Medicaid Services
CPO	Care Plan Oversight
HCPCS	HCFA (currently known as CMS) Common Procedure Coding System
HHA	Home Health Agency
MCM	Medicare Carriers Manual
PET	Provider Education and Training
POC	Plan of Care
PSP	Provider/Supplier Service Plan
Triple S	Seguros de Servicios de Salud de Puerto Rico - Medicare Carrier

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INTRODUCTION

BACKGROUND

The Medicare program was established under Title XVIII of the Social Security Act, as per Social Security Amendments of 1965. Medicare is a health insurance program providing health coverage for people age 65 and over, those who have permanent kidney failure, and certain people with disabilities. The program is administered by the Centers for Medicare & Medicaid Services (CMS). Administration of the Medicare Part B program is contracted to carriers and covers physician services, including care plan oversight (CPO) services, and other health care providers not covered by Part A. Seguros de Servicios de Salud de Puerto Rico (Triple S) serves as the Medicare carrier for the Commonwealth of Puerto Rico and the U.S. Virgin Islands.

The Medicare Carriers Manual (MCM) Part 3 contains the CMS billing requirements for CPO services rendered by physicians. CPO services are to be provided by physicians to beneficiaries that are receiving services by a home health agency (HHA) or hospice under an approved plan of care (POC). The Medicare coverage for this service became effective January 1, 1995.

Specifically, the MCM Part 3, Chapter XV - *Fee Schedule for Physicians' Service* - Section 15513 (A) *Codes for Which Separate Payment May Be Made* allowed a separate payment for HCPCS code 99375 for CPO services only if the requirements specified in subsection B are met. During subsequent years, new HCPCS codes were issued for CPO services to differentiate among patients receiving home health or hospice services, as follows:

Effective Dates	***Code***	***CPO services covered***
January 1, 1997 through March 31, 1998	GO64, GO65, and GO66	Medicare beneficiaries receiving home health or hospice services
January 1, 1998 through December 31, 2000	99375	Medicare beneficiaries receiving home health
	99378	Medicare beneficiaries receiving hospice
January 1, 2001 through Present.	G0179	Physician re-certification for home health
	G0180	Physician certification for home health
	G0181	Physician supervision for home health
	G0182	Physician supervision for hospice

In addition, Section 15513 (B) *Requirements for Payment* requires that physicians may bill and be paid separately for CPO services only if all of the following billing requirements are met:

- The beneficiary to whom the services are furnished was receiving Medicare covered HHA or hospice services during the period in which the care plan oversight services were furnished;

- The physician who bills CPO services must be the same physician who signed the HHA or hospice plan of care;

- The CPO services are personally furnished by the physician who bills them;

- The work included in a hospital discharge day management and discharge from observation is not countable toward the 30 minutes per month required for work on the same day as discharge but only for those services separately documented as occurring after the patient is actually physically discharged from the hospital;

- The physician provided a covered physician service that required a face-to-face encounter with the beneficiary within the 6 months immediately preceding the provision of the first CPO service;

- The physician furnished at least 30 minutes of CPO services within the calendar month for which payment is claimed;

- The physician billing for CPO services must document in the patient's record what services were furnished and the date and length of time associated with those services;

- If the beneficiary is receiving HHA services, the physician did not have a significant financial or contractual interest in the HHA;

- The physician is not billing for Medicare end stage renal dialysis (ESRD) capitation payment for the same beneficiary during the same month;

- The beneficiary required complex or multi-disciplinary care modalities requiring ongoing physician involvement in the patient's plan of care;

- The care plan oversight services billed by the physician was not routine post-operative care provided in the global surgical period of a surgical procedure billed by the physician; and

- Services provided incident to a physician's service do not qualify as CPO and do not count toward the 30-minute requirement.

Further, Section 15513 (C) *Nature of Services*, provides that:

> "CPO is the physician supervision of patients under the care of home health agencies or hospices that require complex or multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of related laboratory and other studies, communication with other health professionals not employed in the same practice who are involved in the patient's care, integration of new information into the medical treatment plan, and /or adjustment of medical therapy.
>
> Services not countable toward the 30 minutes threshold that must be provided in order to bill for CPO include, but are not limited to, time associated with discussions with the patient, his or her family or friends to adjust medication or treatment, time spent by staff getting or filing charts, travel time, and or physician's time spent telephoning in to the pharmacist unless the telephone conversation involves discussions of pharmaceutical therapies.
>
> Implicit in the concept of CPO is the expectation that the physician has coordinated an aspect of the patient's care with the HHA or hospice during the month for which CPO services were billed."

One of the requirements for the physician to bill separately for CPO services is that the physician has to furnish at least 30 minutes of CPO within the calendar month for which payment is claimed. During our audit period, services countable to the 30 minutes included the following:

- Physician development and/or revision of POC;
- Review of subsequent reports of patient status;
- Review of related laboratory and other studies;
- Communication with other health professionals not employed in the same practice who are involved in the patient's care; and
- Integration of new information into the medical treatment plan, and/or adjustment of medical therapy.

The length of time accumulated for any of the above services must be documented with notations in the patient's medical record. The physician can bill Medicare only for one monthly CPO service when the aggregate time is at least 30 minutes during the calendar month.

Starting in January 1, 2001 separate CPO procedure codes were created for the physician certification and re-certification of POC for covered HHA services. In addition, new codes were defined for the physician supervision for patients under HHA and hospice coverage. Prior to that date, the same procedure code (99375 for HHA and 99378 for hospice) was used to bill for all the services related to the CPO.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of this review was to determine whether claims for CPO services rendered by physicians in Puerto Rico were paid in accordance with Medicare requirements.

Scope

Our review was conducted in accordance with generally accepted government auditing standards. The audit included a universe of 37,020 claims totaling $2,159,018 paid to 983 physicians for CPO services rendered during the period January 1, 1999 through December 31, 2000. The universe is comprised of 37,001 claims for patients with HHA coverage and 19 claims for hospice patients, representing $2,157,970 and $1,048 paid respectively under procedure codes 99375 (HHA) and 99378 (hospice).

Our fieldwork was performed at the Medicare carrier, HHAs and physician offices throughout Puerto Rico during the period November 2002 through January 2003. We did not assess the overall internal control structure of Triple S. Rather, our internal control review was limited to gaining an understanding of those controls related to payments made by Triple S for CPO services rendered by physicians during our audit period and conducting substantive testing.

Methodology

To accomplish our objective, we:

- Reviewed criteria related to the reimbursement of Medicare CPO services;

- Used simple random sampling techniques to select a sample of 30 claims, corresponding to 28 physicians, from the universe of 37,020 CPO claims representing $2,159,018 paid by the Carrier to 983 physicians. There were no CPO claims for hospice care in our sample. For these 30 claims, we obtained documentation that included details of the charges and verified that the claims were for CPO services;

- Determined the names and related information for the 30 beneficiaries in our sample and identified the corresponding physicians and HHAs;

- Obtained documentation from HHAs pertaining to the plan of treatment and progress reports sent to physicians during the CPO period identified in our sample;

- Interviewed physicians and obtained documentation of beneficiary's medical record related to the CPO claims included in our sample and whether they had a financial or contractual interest in the HHA;

- Discussed with Triple S officials the CPO billing requirements, system edits for processing CPO claims, and applicable guidelines they issued related to CPO services; and

- Discussed with CMS the CPO billing requirements and applicable CMS guidelines for recovery of identified overpayments.

FINDINGS AND RECOMMENDATIONS

There is a significant problem with physician claims to Medicare for reimbursement of CPO services in Puerto Rico. Physicians are billing for CPO services but are not adhering to the Medicare requirements that govern CPO services. Although physicians met a few of the general billing requirements, we found that in all 30 claims tested, physicians did not maintain required supporting documentation in their medical records to establish that reimbursable CPO services had actually been provided and that their billings to Medicare were proper and justified.

Because we found all 30 claims in our random sample were in error, there is a significant risk that $2,159,018 for 37,020 claims was improperly reimbursed by the Medicare carrier to physicians for CPO services rendered during the period January 1, 1999 through December 31, 2000. These 37,020 claims were paid to 983 physicians with reimbursements ranging from a high of $50,771 to a low of $28.

Our review disclosed that physicians were not aware of the Medicare billing requirements although Triple S had published them in a 1996 quarterly bulletin. In addition, Triples S included in its quarterly bulletin an explanation of the changes effective in January 2001 and a clarification as to when physicians may bill for CPO services.

Specifically, we found that physicians met the following criteria for billing CPO services:

- The beneficiary to whom the services were furnished was receiving Medicare covered HHA or hospice services during the period in which the care plan oversight services were furnished;

- The physician who billed for the CPO service was the same physician who signed the HHA plan of care;

- The physician provided a covered physician service that required a face-to-face encounter with the beneficiary within the 6 months immediately preceding the provision of the first care plan oversight service;

- The physician did not have a significant financial or contractual interest in the home health agency[1]; and

- The physician did not bill for Medicare for an ESRD capitation payment for the same beneficiary during the same month.

However, we also noted that physicians billing for CPO services did not document in the patient's record what services were furnished and the date and length of time associated with those services, as required by Medicare. Therefore, in the absence of any documentation relative to the CPO services, there was no support to establish that a billable CPO service was rendered.

In general, physicians that we interviewed were not aware of the requirements to bill Medicare for CPO services and some indicated that they did not understand the concept of reimbursement for CPO. We did learn that many believed they were entitled to bill Medicare just for signing the plan of care. However, their belief is entirely unfounded and inconsistent with Medicare requirements. Although Triple S had provided some educational outreach, it is apparent that a much greater effort is needed.

The Medicare program is currently at risk of making improper payments for CPO services because physicians are not adhering to the Medicare requirements and the carrier has not identified this matter as a pattern requiring pre-payment review.

All Sample Claims In Error

We used simple random sampling techniques to select a sample of 30 claims totaling $1,738 from the universe of 37,020 CPO claims representing $2,159,018 paid by Triple S. Our review of documentation maintained by physicians disclosed that all 30 claims were in error because there was no adequate support for the services billed and, therefore, did not meet CPO billing requirements. Specifically,

1. *Medical Records Available For Our Review*

In 27 of the 30 cases we reviewed, where CPO services were claimed, there was no documentation in the patient's medical record regarding the service, date, and length of time associated with the CPO services. During our visits to physicians, we requested documentation for CPO services billed. For 26 claims, the physicians agreed that CPO services notes were not documented in the patients' medical record. Our review of these records confirmed that there were no CPO notes for the period of the sample claims. For one of the 27 claims, the physician was not available for interview because he relocated

[1] This was determined based on interviews with physicians. We did not perform any additional testing.

his practice outside of Puerto Rico. However, we were able to locate the patient's medical record being maintained by another physician. Our review of this medical record showed that, similarly, there was no notation of CPO services.

The MCM Part 3 Section 15513 (B) states that physicians may bill and be paid for CPO services only if all of the billing requirements are met. One of the requirements establishes that CPO services billed by physicians must be documented in the patient's medical record indicating which services were furnished and the date and length of time associated with those services. Documentation supplied by HHA or hospices may not be used in lieu of a physician's documentation.

The following example illustrates claims for which we determined that physicians did not maintain sufficient documentation:

> A physician billed Medicare for providing CPO services to a patient on August 18, 2000 and received reimbursement totaling $56.
>
> We found that the beneficiary's medical record kept by the physician did not have documentation as to the type of service, date, and length of time associated with the CPO services.
>
> Although the physician confirmed signing the plan of care, he indicated that he only treated the beneficiary during the hospitalization and referred the patient for HHA services as part of the discharge planning process from the hospital. After the patient was discharged from the hospital on August 17, 2000, a representative from the HHA brought the POC to the physician for his evaluation and approval.
>
> The MCM Part 3 Section 15513 (B) requires, among others, that the physician billing for CPO must spend at least 30 minutes in a calendar month and document in the patient's record what services were furnished and the date and length of time associated with those services. Contrary to these requirements, we found no evidence in the medical record maintained by the physician supporting the CPO service billed to Medicare.
>
> The physician acknowledged he was not aware of CPO billing requirements, and that he did not document the CPO services in the medical record.
>
> Therefore, we determined that the physician did not maintain adequate supporting documentation for billing CPO services as required by Medicare requirements.

2. ***Medical Records Not Available For Our Review***

We were unable to obtain physicians' medical records for three claims in our sample. For these three claims, the physicians advised us that no documentation was prepared for CPO services rendered. For two of the three claims, the physicians stated that the beneficiaries were under hospital care and referred for HHA services during the discharge process. Since they were the referring physicians, the HHA brought the POC to them for evaluation and approval, but the physicians did not prepare a separate medical record for CPO services. In fact, there was no medical record maintained by these two physicians

for these beneficiaries. Our interviews of the physicians confirmed that they billed for evaluating and authorizing the POC.

In a third case, the physician acknowledged that the beneficiary was his patient while working as a member of a group of physicians. The physician stated that the group is no longer in business and he doesn't know the location of the medical record. However, he informed us that he did not prepare notes for CPO services billed. He acknowledged not being aware of CPO billing requirements, and that he billed for evaluating and authorizing the beneficiary's POC.

Provider Education

We discussed existing educational procedures and the effectiveness of these efforts with Triple S officials. They indicated that Medicare guideline revisions are published in the quarterly Medicare Department bulletin entitled *Medicare Informa*. This bulletin was mailed directly to all physicians participating in the Medicare program. As part of our audit, we were provided with two bulletins issued in November 1996 and January 2001, respectively, which contained information relative to CPO services. We noted that the November 1996 bulletin contained specific instructions and guidance to physicians regarding CPO services. In addition, the January 2001 bulletin explained procedure code changes and a clarification as to when physicians may bill for CPO services.

Although two of the quarterly bulletins issued by Triple S contained instructions for billing CPO services, physicians informed us that they were not aware of the billing requirements. In fact, some physicians told us they were still in medical school when the first bulletin was issued. Other physicians told us they were too busy to read the guidelines contained in the Medicare bulletins. Nonetheless, physicians have an obligation to be aware of the billing requirements when claiming reimbursement from the Medicare program.

Pursuant to the Medicare contract with CMS, one of the functions to be performed by the carriers is to provide training and education to Medicare providers. Sections 1816 (a) and 1842 (a)(3) of the Social Security Act direct contractors to develop provider education and training plan according to guidelines in the Budget Performance Requirements. All carriers are instructed to develop a Provider/Supplier Service Plan (PSP) to support the requirements of each provider education and training (PET) activity and submit it with the budget request. Required PET activities include, among others, inquiry and data analysis, bulletins, seminars, workshops and teleconferences. Outreach and educational efforts are to be developed to address the needs of providers. The carriers must issue regular bulletins/newsletters, at least quarterly, containing billing information. They need also to hold seminars, workshops, classes, and other face-to-face meetings to educate and train providers regarding Medicare program and billing issues.

During our review, we identified the following causes that resulted in the physicians not documenting CPO services in the beneficiary's medical record:

- 27 physicians interviewed[2], corresponding to 29 sample claims, acknowledged that they were not aware of the CPO billing requirements; and

- 11 out of the 27 physicians interviewed also indicated that they do not understand the CPO concept.

Although Triple S officials feel some outreach efforts were in place, it is evident from the results of our review that these efforts are not effective in promoting awareness of CPO billing requirements among the provider community to ensure the appropriate documentation is maintained for this service. Triple S officials confirmed that they have not evaluated the effectiveness of existing outreach efforts for CPO services.

The degree of noncompliance we encountered in our review and the unfamiliarity of physicians with Medicare billing requirements poses a significant risk to the Medicare program for making improper CPO payments. Therefore, we believe Triple S needs to take immediate action.

RECOMMENDATIONS

We recommend that Triple S:

- Develop an action plan targeted towards providing educational outreach in order to promote full awareness of the CPO billing requirements among the physician community;

- Perform periodic post payment review of CPO claims submitted by physicians to ascertain that physicians are adhering to Medicare billing requirements; and

- Conduct additional reviews of claims by physicians with significant CPO billings to recover inappropriate payments that have been made.

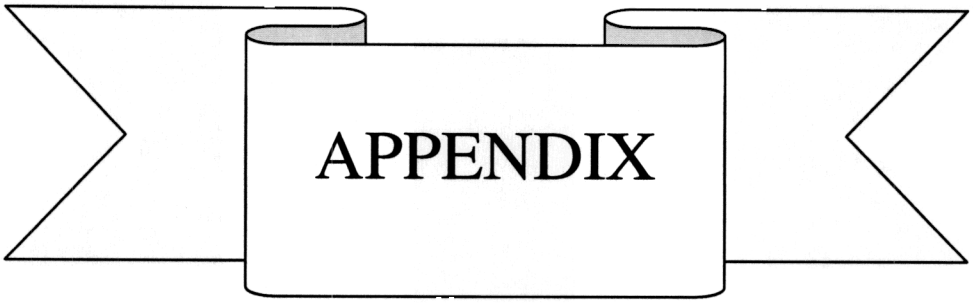
Auditee Comments

In their comments, dated July 29, 2003 Triple S agreed to immediately address our recommendations. Triple S' corrective action plan includes increased provider education and closer review of providers who are claiming CPO reimbursement. Triple S has also taken the initiative to begin recovery of the potential overpayments identified for the 30 claims discussed in our draft report. Triple S' comments are included in their entirety as Appendix A to this report.

[2] One of the 28 physicians was not interviewed because he moved outside of Puerto Rico. However, the beneficiary's medical record was obtained from the medical office now occupied by another physician.

OIG Response

We are pleased to learn that Triple S not only accepts our recommendations but has already begun implementing them. We are encouraged by Triple S' proactive efforts to recover the potential overpayments we identified. The OIG supports this initiative and is providing Triple S officials with the supporting documentation obtained during our audit.


APPENDIX

MEDICARE
Part-B Carrier
Bene. PR & USVI 1-800-981-7015
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July 29, 2003

Mr. Timothy J. Horgan
Regional Inspector General for Audit Services
DHHS, OIG/OAS
26 Federal Plaza, Room 3900
New York, New York 10278

Ref: Report Number A-02-02-01019

Dear Mr. Horgan:

This is in response to your letter dated June 18, 2003[1], regarding the Office of Inspector General Office of Audit Services draft report entitled "Medicare Care Plan Oversight in Puerto Rico".

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

On January 29, 2003, we met with OIG staff auditors to discuss the preliminary report as well as the findings identified during the audit. Since this meeting, we took the following steps in order to immediately address the issues identified:

a. An article was published in the Medicare Informa Bulletin (Vol. 73, January, February, March 2003, pages 51-53). This article explains the Medicare criteria and requirements that need to be present in order for Medicare to pay the service. It is also states that the service needs to be properly documented in the medical record. It is important to mention these previously published articles are available to the providers through our Webpage.

b. We installed an edit in the system that generates an educational letter to every physician that bills CPO codes (Please refer to Attachment "A"). That edit was tested and installed on April 7, 2003. This letter instructs the physician to read these articles published in our Bulletin in order to understand the requirements and the medical documentation that must contain the medical record.

c. A script was developed for the Medicare Customer Service Representatives in order to provide them with a uniform response to the questions that could be received through the call center or correspondence area. The script

[1] Please be advised that in order to obtain the 30day period for submitting comments, a request for extension to answer this report was made and granted by OIG. The reason for this was that the letter was dated June 18, 2003 but we did not receive it in our office until June 30, 2003.

includes the requirements that have to be present when a CPO is billed and that the service needs to be properly documented in the medical record.

d. Although OIG projected the result of this sample to the total universe, the Program Integrity Manual Chapter 3 Section 8.1.1.2 states that in order to recoup a projected overpayment it must be obtained from a Statistic Valid Random Sample (SVRS) to all similar claims in the universe under review. Based on this information, we will proceed to recoup the amount identified for the 30 claims and not the amount associated to the projected overpayment as identified by the OIG auditors. We will contact the OIG staff auditors involved in the audit to obtain the documentation related to the 30 claims incorrectly paid in order to initiate the recoupment process. This information is essential because it will serve as supporting documentation for the overpayment process.

2. In addition to the steps described above, this Carrier is committed to taking the following course of action during the next fiscal year:

   a. As part of our MR Strategy for FY2004, we will be conducting post payment review during the first quarter in order to determine if the providers are in compliance with the Medicare requirements when they bill CPO codes and if the services are properly documented in the medical records. The post payment review will be conducted in accordance with the instructions provided in the Program Integrity Manual, Chapter 3, Sections 2.A, 2.1 and 6. Based on the analysis performed for services paid during 2002, we will be conducting the following activities:

      Provider Specific reviews: An analysis was conducted where we have identified those physicians with the highest number of services billed. A specific provider probe sample will be conducted for each one of them and based on the results; we will conduct a one-on-one meeting with those providers that obtain a 40% or higher error rate in the sample in order to provide educational contact. The claims identified as incorrectly paid will be adjusted in order to recoup the specific amount. These providers will also be subject to a prepayment review.

      ii. **Widespread review**: A sample of 100 claims will be selected for review in order to verify if the service was provided in accordance with the Medicare Regulation and that the medical records contain the adequate documentation of the service provided. The providers identify in item "i" will be excluded from this review. If the results obtain is a 40% or higher error rate, the code will be subject to prepayment review. The providers will also be subject to having their claims adjusted if they are identified as incorrectly paid.

b. After the review is completed, an article will be published in the Medicare Informa Bulletin in order to share with the physician community the results obtained from the MR post payment review.

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. Lebron, Esq.
Vice President
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[redacted]

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