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
October 21, 2003

Report Number: A-02-02-01014

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

Dear Ms. Lebrón:

Attached is a copy of our final report providing the results of our self-initiated "Review of Unlicensed Providers in Puerto Rico." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

The objective of the audit was to determine whether unlicensed providers in Puerto Rico were:

- submitting claims for services rendered to Medicare beneficiaries;
- submitting Medicare claims that indicated cause for concerns relating to quality of care or program abuse, and/or
- continuing to receive Medicare payments.

Medicare laws and regulations at Social Security Act § 1861 and 42 CFR 410.41 require that providers must comply with State and local licensure and certification requirements. The CMS has also established guidelines in the Medicare Carriers Manual, Part III §§ 2070.1 and 2120.1 and Part IV §§ 1001, Chapter 6 of the State Operations Manual and Chapter 10 of the Medicare Program Integrity Manual for both providers and Medicare contractors with respect to establishing whether a provider is eligible to render services to Medicare beneficiaries. In addition to compliance with the Federal laws, regulations and guidelines mentioned above, Medicare providers and contractors must follow the regulations of the local licensing authorities in Puerto Rico such as Article 5 of the Regulations of the Board of Medical Examiners and Department of Health Regulations, Article 92 and §§ 4.04 and 14.04 and the requirements of the Clinical Laboratory Improvement Amendments of 1988.

The results of our review disclosed that, because of weaknesses in Triple-S's procedures, 63 unlicensed physicians, ambulance companies and independent clinical laboratories in Puerto Rico received payments totaling $3,607,820 between July 1, 1998 and December 28, 2001 for periods when they were not properly certified to render services to Medicare beneficiaries. We also found that Triple-S and the Office of Inspector General (OIG) increased their oversight of 24 of the unlicensed providers because of concerns about the providers' billing and utilization

patterns and other complaints. Our findings were primarily based on records at the Puerto Rico licensing authorities or at Triple-S. In addition, we gathered information from OIG and CMS databases.

We are recommending that Triple-S:

- more closely monitor provider enrollment procedures to ensure the integrity of the process and to better protect the interests of the Medicare beneficiaries and the Medicare program;

- coordinate with the CMS Regional Office to develop a plan to resolve the $3,607,820 in payments made to the unlicensed providers;

- take steps to preclude any Medicare payments to providers that are not certified and, therefore, not eligible to provide medical or other health services; and

- establish a closer communication with Commonwealth licensing agencies in order to develop a permanent exchange of information about all providers that are not complying with licensing requirements.

In written comments, Triple-S generally concurred with our recommendations but expressed concerns about the amount of the overpayments to unlicensed physicians and ambulance companies in our draft report. Based on our review of your response to the draft report and our evaluation of additional documentation that Triple-S obtained from the providers after our fieldwork period, we reduced the reported overpayments to physicians by $4,974 and the reported overpayments to ambulance companies by $277,998. In general, however, we found that the additional documentation presented to us was inadequate or inconclusive to reach an informed conclusion as to whether the overpayments should be reduced.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. 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 may 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, Office of Inspector General, OAS reports issued to the Department's grantees and contractors are made available to members of the 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.)

To facilitate identification, please refer to Report Number A-02-02-01014 in all correspondence. Any questions or further comments on any aspect of the report are welcome. Please address them to me at (212) 264-4620 or through e-mail at thornan@oig.hhs.gov.

Sincerely,

Timothy J. Horgan
Regional Inspector General
for Audit Services

Attachment

Direct Reply to HHS Action Official:

Dr. Gilbert Kunken, Acting Regional Administrator
Centers for Medicare & Medicaid Services
26 Federal Plaza, Room 3811
New York, NY 10278

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF UNLICENSED PROVIDERS IN PUERTO RICO

Inspector General

SEPTEMBER 2003
A-02-02-01014

Office of Inspector General

http://oig.hhs.gov

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Executive Summary

The objective of the audit was to determine whether unlicensed providers in Puerto Rico were:

- submitting claims for services rendered to Medicare beneficiaries;
- submitting Medicare claims that indicated cause for concerns relating to quality of care or program abuse, and/or
- continuing to receive Medicare payments.

Our review disclosed that 63 of the over 7,000 providers serviced by Triple-S were not certified by the appropriate licensing agencies and were, therefore, not eligible, under Medicare laws and regulations, to claim payment for services provided to Medicare beneficiaries. Medicare laws and regulations require that providers must comply with State and local licensure and certification requirements. The CMS has also established guidelines in the Medicare Carriers Manual and the Medicare Program Integrity Manual for both providers and Medicare contractors with respect to establishing whether a provider is eligible to render services to Medicare beneficiaries. In addition, we considered the local licensing authorities' regulations and the requirements of the Clinical Laboratory Improvement Amendments of 1988.

The results of our review of files at Triple-S and at the licensing agencies in Puerto Rico, illustrated in the table below, disclosed that unlicensed physicians, ambulance companies and independent clinical laboratories received payments between July 1, 1998 and December 28, 2001 as follows:

Physicians	36	$2,246,591
Ambulance Companies	22	1,247,842
Independent Laboratories	5	113,387
	63	$3,607,820

We also observed that Triple-S and the Office of Inspector General (OIG) increased their oversight of 24 of the 63 unlicensed providers because of concerns about the providers' billing and utilization patterns as well as complaints, as noted below:

- In nine instances, unlicensed physicians were being monitored by Triple-S because of beneficiary complaints or aberrant billing and utilization patterns.

- In 15 instances, ambulance companies are being monitored by Triple-S, or OIG, for violations of Medicare utilization guidelines and beneficiary complaints.

Furthermore, each of the five unlicensed laboratories did not renew their required certifications under the Clinical Laboratory Improvement Amendments of 1988 (CLIA). We, therefore, concluded that expired licenses appear to be early indicators that the laboratory will not continue to maintain the required CLIA certification.

In addition, one of the five unlicensed laboratories was denied a license renewal because it did not meet the quality of care and patient safety standards of the licensing agency.

In general, the 63 unlicensed providers were continuing to receive Medicare payments because of weaknesses in Triple-S's procedures. Based on our audit, Triple-S has recently improved its procedures for monitoring provider licenses.

[redacted]

As discussed below, we encourage Triple-S to coordinate its efforts with the CMS Regional Office to determine the most appropriate means of resolving the matters discussed in this report. Specifically, we recommend that Triple-S:

- more closely monitor provider enrollment procedures to ensure the integrity of the process and to better protect the interests of the Medicare beneficiaries and the Medicare program;

- coordinate with the CMS Regional Office to develop a plan to resolve the $3,607,820 in payments made to the unlicensed providers;

- take steps to preclude any Medicare payments to providers that are not certified and, therefore, not eligible to provide medical or other health services; and

- establish a closer communication with Commonwealth licensing agencies in order to develop a permanent exchange of information about all providers that are not complying with licensing requirements.

[redacted]

Triple-S, in its response dated January 17, 2003, but received by OIG on February 20, 2003, generally concurred with the recommendations in the report. They did, however, express concerns about the reported overpayments to unlicensed physicians and ambulance companies. Specifically, the response appears to indicate that Triple-S believes that the reported overpayments to physicians should be reduced by $783,242 and the reported overpayments to ambulance companies should be reduced by $321,156. The full text of Triple-S's response is presented at Appendix B.

[redacted]

Based on our review of the response to the draft report, our discussions with Triple-S officials about the matters discussed in the response and our evaluation of the additional documentation

that Triple-S obtained from the providers after our fieldwork period, we reduced the reported overpayments to physicians by $4,974 and the reported overpayments to ambulance companies by $277,998. In total, the reported overpayments were reduced from $3,890,792 for 67 providers to $3,607,820 for 63 providers.

With respect to the remaining adjustments proposed by Triple-S, we generally found that the additional documentation presented to us was inadequate or inconclusive to reach an informed conclusion as to whether the overpayments should be reduced.

TABLE OF CONTENTS

	Page
INTRODUCTION……	1
BACKGROUND ……	1
OBJECTIVE, SCOPE AND METHODOLOGY	
Objective……	2
Scope…….	2
Methodology…….	2
FINDING AND RECOMMENDATIONS	
CRITERIA……	3
UNLICENSED PROVIDERS…….	4
Physicians……..……	4
Ambulance Companies…….……..……..……	6
Independent Clinical Laboratories……..……..……	7
Conclusions…….…….……	9
RECOMMENDATIONS……	10
AUDITEE RESPONSE……..	10
OIG COMMENTS……..	11
	APPENDIX
FEDERAL AND COMMONWEALTH GUIDELINES……	A
AUDITEE RESPONSE ……...	B
RECONCILIATION, AUDITEE RESPONSE TO TABLES I AND II.	C

CLIA	Clinical Laboratory Improvement Amendments of 1988
CMS	Centers for Medicare & Medicaid Services
Commission	Comisión de Servicio Público *(Public Service Commission)*
FAA	Federal Aviation Administration
MCM	Medicare Carriers Manual
OIG	Department of Health and Human Services, Office of Inspector General
SARAFS	Departamento de Salud de Puerto Rico/Secretaría Auxiliar para Reglamentación y Acreditación de Facilidades de Salud (*Puerto Rico Department of Health/Secretariat for Regulation and Accreditation of Health Facilities*)
TEM	Departamento de Salud de Puerto Rico/Tribunal Examinador de Médicos (*Puerto Rico Department of Health/Board of Medical Examiners*)
Triple-S	Seguros de Servicios de Salud de Puerto Rico, Medicare Carrier

INTRODUCTION

The Medicare program was established under Title XVIII of the Social Security Act by the Social Security Amendments of 1965 (the Act). 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 A program is contracted to fiscal intermediaries and covers inpatient hospital care, skilled nursing facilities, hospice, and home health care. Administration of the Medicare Part B program is contracted to carriers and covers physician services, outpatient hospital care, and other health care providers' services not covered by Part A, such as ambulance and clinical laboratory services.

A Medicare carrier is responsible for adjudicating Medicare Part B claims to authorize providers in accordance with the provisions of the Act, Federal regulations, and guidelines issued by CMS. 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, processing over 7 million Medicare claims a year for over 7,000 providers serving approximately 400,000 beneficiaries.

The CMS guidelines in the Medicare Program Integrity Manual define provider and supplier enrollment as critical functions designed to ensure that only qualified and eligible individuals and entities are enrolled in the Medicare program and receive reimbursement for services furnished to beneficiaries. Specific CMS guidelines issued to Medicare contractors in the Medicare Carriers Manual (MCM) implement this policy by requiring carriers to coordinate with State licensing agencies when evaluating qualifications of health care practitioners. For example, MCM Part 3 § 2020.1 and Part 4 § 1001 indicate that Medicare covers services rendered by physicians, health practitioners and practice groups who are legally authorized to practice in the locality where the medical services are rendered.

In the Commonwealth of Puerto Rico, providers are regulated by the following agencies under the Puerto Rico Department of Health:

- Tribunal Examinador de Médicos (TEM) or, the *Board of Medical Examiners* regulates the practice of medicine by qualified physicians.

- Secretaría Auxiliar para la Reglamentación y Acreditación de Facilidades de la Salud (SARAFS), or the *Secretariat for the Regulation and Accreditation of Health Facilities* regulates, among others, ambulance providers and independent clinical laboratories.

Our prior review, limited to 304 providers, noted deficiencies in the provider enrollment processes at Triple-S[1]. That review also indicated that Medicare payments were made to a physician without a current license.

[1] See *"Review of Provider Eligibility Files at Triple-S Inc."* (Common Identification Number A-02-02-01048)

OBJECTIVE, SCOPE AND METHODOLOGY

The objective of the audit was to determine whether unlicensed providers in Puerto Rico were:

- submitting claims for services rendered to Medicare beneficiaries;
- submitting Medicare claims that indicated cause for concerns relating to quality of care or program abuse, and/or
- continuing to receive Medicare payments.

To accomplish our objective, we:

- reviewed applicable sections of the Medicare laws and regulations, the MCM and the regulations of the local licensing agencies;
- obtained information from TEM and SARAFS about their licensure and registration requirements;
- held discussions with CMS officials about their policies with respect to provider eligibility and enrollment matters;
- reviewed information in provider case files maintained by Triple-S, TEM and SARAFS;
- reviewed information maintained on Office of Inspector General (OIG) and contractor databases and,
- held discussions with Triple-S officials about their internal control structure as it relates to the eligibility problems identified through this review.

The audit included payments made through December 28, 2001 for services rendered between July 1998 and December 2001.

The audit was performed in accordance with generally accepted government auditing standards. The objective required that we gain a limited understanding of controls developed by Triple-S with respect to the monitoring of Medicare providers' licenses. The fieldwork was performed at Triple-S, TEM and SARAFS facilities in Puerto Rico from January 2002 to September 2002.

We obtained from Triple-S a database of 12,005 Medicare provider numbers representing approximately 7,000 active Medicare providers as of December 2001.[2]

[2] Some providers have more than one provider number. For example, a physician in a group practice and also in a private practice separate and distinct from the group would generally have two different provider numbers.

For physicians, we examined files of providers who had not sent completed renewal applications to TEM. From these records, we compiled a listing of 1,150 physicians (535 physicians who had not registered for the 3-year period ended June 2001 and 615 physicians who had not registered for the 3-year period beginning July 2001). We then matched these physicians against the Triple-S database to determine if Medicare payments had been made to ineligible providers.

For the ambulance and independent clinical laboratory providers, we compared providers on the Triple-S database to SARAFS records in order to determine whether the providers were properly licensed.

[redacted]

The review indicated that 63 (approximately 1%) of the over 7,000 providers serviced by Triple-S were not certified by the appropriate licensing agencies and were, therefore, not eligible to render service to Medicare beneficiaries. We also found that these 63 physicians, ambulance companies and independent clinical laboratories in Puerto Rico were improperly paid $3,607,820 for services rendered between July 1998 and December 2001 and were continuing to receive Medicare payments. Finally, the results also indicated that Triple-S or OIG had increased their oversight of 24 (approximately 38%) of the 63 unlicensed providers due to concerns about the providers' billing patterns, utilization of medical services and/or complaints. Triple-S's corrective actions in response to our audits appear to have both reduced the amount paid to unlicensed physicians and also improved the procedures for monitoring provider licenses. As discussed below, we recommend that Triple-S improve its provider enrollment procedures, preclude additional payments to ineligible providers and improve communications with the licensing agencies in Puerto Rico. We also encourage Triple-S to coordinate efforts with the CMS Regional Office to resolve the matters discussed in this report.

[redacted]

Medicare laws and regulations require that providers must comply with State and local licensure and certification requirements. The CMS has also established guidelines for both providers and Medicare contractors with respect to establishing whether a provider is eligible to render services to Medicare beneficiaries. In general, these guidelines in the Medicare Carriers Manual and the Medicare Program Integrity Manual require that providers maintain appropriate licenses and that contractors:

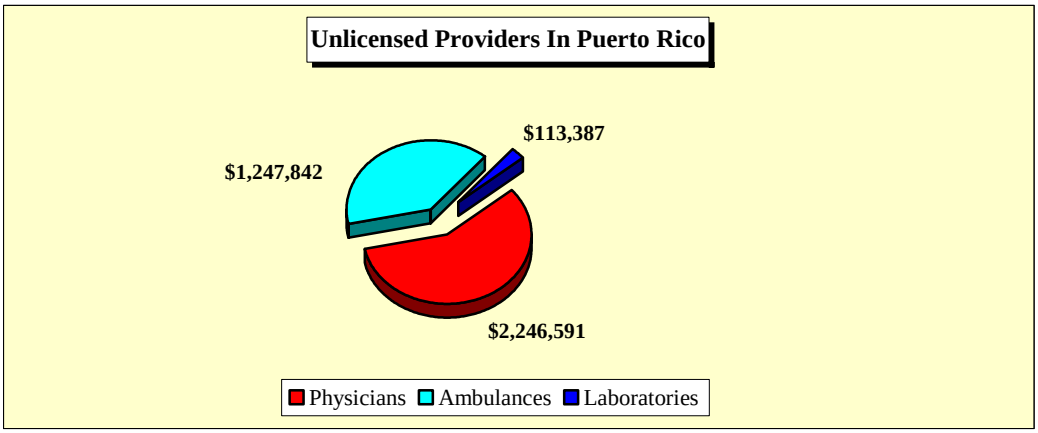
- validate the providers' credentials and
- confirm with State licensing authorities that provider licenses and registrations are currently in effect.

Consequently, we considered the Medicare laws and regulations, the CMS guidelines and the local licensing authorities' regulations in conducting this review. Specifically, the licensing authority for physicians and ambulance providers in Puerto Rico are TEM and SARAFS, respectively. In addition to the credentialing and licensing requirements noted above, independent clinical laboratories must conform to the requirements of the Clinical Laboratory

Improvement Amendments of 1988 (CLIA). The SARAFS monitors laboratory providers' licenses as well as their compliance with the CLIA standards.

Further details about the specific CMS and local guidelines applicable to physicians, ambulance providers and independent clinical laboratories in Puerto Rico are included in Appendix A.

We identified 63 unlicensed providers who received Medicare payments totaling $3,607,820 during the audit period, as illustrated below:



Triple-S and TEM records disclosed that for

TEM requires that for a physician to practice any medical specialty, the professional must submit a completed questionnaire attesting to compliance with continuing education requirements and Commonwealth laws within prescribed time frames. In general, timely registrations must be filed within 30 days of receipt of the registration renewal materials from TEM.[3] Timely registrations result in the issuance of a license for the entire 3-year registration period. Late registrations, however, result in the issuance of certificates that only apply to the remaining months of the 3-year period. Although system upgrades and improved data exchanges with other agencies have not yet been fully implemented to assure appropriate oversight of registrations, TEM has informed us that most physicians submit the registration materials on a timely basis.

[3] The most recent uniform 3-year registration periods began on July 1, 1998 and July 1, 2001. For the period beginning July 1, 2001 only, the registration period was extended to 90 days after the beginning of the registration period.

Triple-S's files generally include a copy of the most recent TEM certificates to document the physician's current licensing status. If evidence of current registration is not on file, Triple-S corresponds directly with the physician and, on occasion, with TEM. We noted instances, however, when Triple-S's files did not contain proper evidence of the physician's current registration with TEM.

Specifically, for the 3-year registration period ended June 30, 2001, our comparison of TEM and Triple-S files indicated that 74 physicians on the Triple-S database had not registered with TEM. We found that 27 of these physicians received Medicare payments for periods when they were not eligible to practice medicine according to the evidence in TEM and Triple-S files. For example, an "unlicensed" provider had actually died before the start of the 3-year registration period. Although Triple-S records indicated that Medicare paid $931 for services rendered by this physician between July 1998 and June 2001, the physician had passed away in August 1995.

For the subsequent registration period beginning July 1, 2001, the comparison of TEM and Triple-S files indicated that 84 physicians on the Triple-S database had not registered with TEM. We noted that nine of these physicians who were not eligible to bill the Medicare program for certain periods received payments for services during those periods. In six of these instances, the physicians registered with TEM late. In the remaining three instances, despite correspondence to the physicians from Triple-S, there was no evidence on file that the physicians had submitted license renewal applications.

In addition to its function as a professional licensing agency, TEM is also responsible for monitoring the quality of care by physicians. One of the prescribed means of carrying out this mandate is through documenting malpractice and beneficiary complaints and referring the complaints to the Commonwealth's Department of Justice. Although we found no evidence of complaints or quality of care referrals in the TEM files for the unlicensed physicians, we noted that TEM has been criticized for lack of oversight in this regard.

Since TEM files were limited to materials directly related to the licensing processes, we sought other methods to determine if the failure to maintain current licenses and/or registrations was associated with quality of care issues. From the limited information available in Triple-S files, we noted nine instances when Triple-S was monitoring unlicensed physicians because of beneficiary complaints or aberrant billing and utilization patterns.

For example, one physician was not licensed for the 3-year period ended June 30, 2001 and registered late for the 3-year period beginning July 1, 2001. Payments for services rendered during periods when this physician was not authorized to practice medicine in Puerto Rico amounted to $501,249. Triple-S files indicate that the physician is presently undergoing expanded focused medical review due to aberrant billing and utilization patterns with respect to a particular medical procedure.

As previously discussed, 74 unlicensed providers remained on Triple-S's active files for the 3-year registration period ended June 30, 2001. We learned that for this period, Triple-S was not performing effective checks of its files to detect physicians for whom they had no current

licensing information. Recent improvements in Triple-S processes, including provider education and information efforts initiated in response to our prior audit, have reduced the number of unlicensed physicians receiving Medicare payments from 27 providers in the 3-year period ended June 30, 2001 to only nine providers in the 3-year registration period that began on July 1, 2001.

None of the ambulances used by 22

Ambulance companies are required to comply with Commonwealth licensure requirements on an annual basis. SARAFS regulates the 1-year certifications issued to ambulance providers in Puerto Rico. For these providers, SARAFS also requires that every ambulance unit be inspected every 5 years by the Comisión de Servicio Público, or *Public Service Commission* [Commission]). SARAFS will not issue a certification unless there is evidence on file that the Commission has already reviewed the ambulance crew's credentials and inspected the ambulance(s). As part of its annual certification process, SARAFS also performs on-site safety inspections of each ambulance unit and performs tests to ensure that the equipment on board the ambulance is in good working order.

Although Medicare regulations require that ambulance companies comply with licensure and certification requirements specified by State and local laws, our review indicated that 49 (approximately 31%) of the 157 ambulance companies on the Triple-S database had been paid for CCservices during periods when one or more of their ambulances or crews were not certified by SARAFS. These 49 providers operated a total of 286 ambulance units for which they received Medicare payments totaling $14,264,056 during the audit period.

The provider files in Triple-S's claims processing system contain licensing information for an ambulance company as a whole, rather than for individual ambulance units. Accordingly, licensing information about a single ambulance unit may result in paying claims for any of the ambulances operated by the ambulance company. In addition, claims for ambulance services do not identify the specific ambulance unit that responded to the call. Therefore, without a detailed review of the underlying provider records, which we considered to be beyond the scope of our review, it was not possible to determine the total extent to which Medicare payments were made for ambulance units that were not certified by SARAFS. Accordingly, we limited the scope of this aspect of the review to 22 ambulance companies for which no ambulance units were certified by SARAFS during specific 1-year certification periods within the audit time frames.

In general, the results of our review of these 22 providers, which are illustrated in the table below, indicated that Triple-S's processes for monitoring the certification of ambulance companies need improvement.

10	2,720	No evidence in SARAFS or Triple-S records that any of the ambulance units were certified.
6	1,969	No certification on file for certain years.
6	408	Improper evidence of certification in Triple-S files.

For example, for two of the six providers authorized to render services only for specific years within the audit period, it appears that Triple-S mistakenly used certification documents from different periods to determine the providers' eligibility.

We also noted that preliminary inspection checklists or endorsement letters were apparently accepted as evidence of licensing for five of the six providers by Triple-S. However, neither of these documents is considered valid evidence of certification. For example, an endorsement letter is simply an authorization issued by SARAFS to allow the provider to continue with an inspection. For one of the five providers, the certification evidence in Triple-S records was for a different ambulance company.

With respect to concerns about program abuse among unlicensed providers, we observed that 15 of the 22 unlicensed ambulance companies were being monitored by Triple-S or OIG for violations of Medicare utilization guidelines and beneficiary complaints.

In general, we found that the 22 unlicensed providers continued to receive Medicare payments because of Triple-S's inability to monitor the licensing status of ambulance companies. For example, limitations in the provider files and the claims data, as described above, could result in updates that reflect licensing information for only the most recently licensed ambulance unit. In addition, Triple-S was not always diligent in monitoring providers that did not submit current registration information. For example, SARAFS has been supplying the contractor with monthly listings of ambulance units that were newly certified or re-certified. In our opinion, careful use of these listings could significantly reduce the likelihood of Triple-S's making payments to unlicensed ambulance companies or for unlicensed units.

[redacted]

[redacted]

Independent clinical laboratories must comply with Commonwealth licensure requirements on an annual basis. SARAFS issues licenses and also performs the oversight

provisions of the CLIA program before issuing certificates of CLIA compliance. CLIA inspections are conducted once every 2 years.

CLIA was enacted by Congress to ensure the accuracy, reliability and timeliness of patient test results. For example, CLIA specifies quality standards for proficiency testing, patient test management, quality control, personnel qualifications and quality assurance for laboratories. In performing its CLIA inspections, therefore, SARAFS assures the integrity of laboratory results by reviewing procedures relating to the handling and processing of laboratory specimens.

For the independent clinical laboratory providers, we compared the 619 independent clinical laboratory providers on the Triple-S database to SARAFS records in order to determine whether the providers were properly licensed according to both Commonwealth and CLIA regulations. We found that five of the 619 laboratories had rendered service to Medicare beneficiaries after their licenses or CLIA registrations had expired. Specifically,

- Two laboratories continued to submit Medicare claims after their CLIA and Commonwealth licenses had expired in June 2000. Triple-S paid $2,299 for these 162 claims as of December 2001.

- Three laboratories had effective CLIA certificates; however, they were operating under expired licenses from the Commonwealth. For example, as of December 2001, a laboratory had received $109,433[4] for services rendered after the expiration of its Commonwealth license in June 2000. Although the laboratory had an effective CLIA certificate at that time, a SARAFS survey in June 2001 indicated that the laboratory was not complying with CLIA requirements. Since the provider did not submit a Plan of Correction to address these matters, the CLIA certificate was suspended in December 2001 and revoked in March 2002.

It is also worth noting that expired licenses for laboratory providers appear to provide early indications that the laboratory will not continue to maintain CLIA certification. Specifically, after each of the five laboratories above had not renewed their licenses, their CLIA certifications were not renewed.

With respect to independent clinical laboratories, we learned that Triple-S had been monitoring the providers' CLIA certifications, but had not been contacting the providers or SARAFS for licensing information. Therefore, the fact that the vast majority of laboratories were properly licensed appears to reflect the fact that providers with CLIA certifications also generally maintain current licenses. On the other hand, Triple-S officials were unable to explain why the two laboratory providers without CLIA certification escaped their attention and continued to receive Medicare payments. For the three unlicensed laboratories, we conclude that they continued to remain on the "active provider" list because Triple-S had not been monitoring the licensing information for this type of provider.

[4] The payments related to 3,664 Medicare claims.

As discussed above, expiration of a laboratory provider's license appears to be a good indicator that the provider will not remain certified under CLIA. In its response to our findings, the

Carrier recognized the importance of the SARAFS certification by modifying their procedures to request licensing information from laboratories starting in 2002.

As previously noted, Triple-S services over 7,000 providers; through this review, we noted that 63 (approximately 1%) of these providers were not eligible under Medicare laws and regulations to render service to Medicare beneficiaries under CMS guidelines. The review indicated that Medicare payments totaling $3,607,820 were issued to the 63 unlicensed providers between July 1, 1998 and December 28, 2001. We also observed that Triple-S or OIG had increased their oversight of 24 (approximately 38%) of the 63 unlicensed providers due to concerns about the providers' billing and utilization patterns as well as complaints.

Medicare laws and regulations require providers to comply with State and local licensing requirements. With respect to activity by the local licensing authorities, we note that SARAFS and its partner agencies also monitor patient safety and quality of care issues related to ambulance companies and independent clinical laboratories. As discussed above, deficiencies noted by SARAFS can result in the denial of a license or CLIA certification. Although TEM has been criticized with respect to its monitoring of quality of care, beneficiary complaints to Triple-S or the OIG provide at least limited information about concerns regarding the quality of physician services. Finally, monitoring by Triple-S has identified instances of aberrant billing and utilization patterns among the unlicensed providers.

As a result of our prior audit, which focused on physician eligibility, Triple-S initiated education and information efforts to remind its providers to submit their registration materials on a timely basis. In addition, Triple-S increased its monitoring of physicians who did not furnish evidence of registration on a timely basis. The results of this audit indicate that while 27 physicians were paid for services while they were unlicensed during the TEM registration period ended in June 2001, only nine unlicensed physicians were paid for services during the current TEM registration period. We believe that these results, on the whole, indicate the success of Triple-S's increased attention to the monitoring of physician licensing.

The licensing authorities in Puerto Rico have expressed interest in increased communications with Triple-S in order to share information and to protect beneficiary interests through strengthened monitoring of providers. In this regard, we note that Triple-S has recently arranged exchanges of information with SARAFS about ambulance providers and also scheduled a meeting with TEM to discuss matters related to both the current and the prior audits.

We believe that increased communications between Triple-S and the licensing authorities can help safeguard Medicare beneficiaries' interests by reducing concerns about the quality of care rendered and billing and utilization improprieties. At the same time, improved exchanges of information may reduce Medicare payments to providers who are not eligible to participate in the Medicare program.

We recommend that Triple-S:

- more closely monitor provider enrollment procedures to ensure the integrity of the process and to better protect the interests of the Medicare beneficiaries and the Medicare program;

- coordinate with the CMS Regional Office to develop a plan to resolve the $3,607,820 in payments made to the unlicensed providers;

- take steps to preclude any Medicare payments to providers that are not certified and, therefore, not eligible to provide medical or other health services, and

- establish a closer communication with Commonwealth licensing agencies in order to develop a permanent exchange of information about all providers that are not complying with licensing requirements.

Triple-S, in its response dated January 17, 2003 (but received by OIG on February 20, 2003), generally concurred with the recommendations in the report. They did, however, express concerns about the reported overpayments to unlicensed physicians and unlicensed ambulance companies, as follows:

- Unlicensed providers – Triple-S voiced concerns about the manner in which TEM issues the triennial licenses and commented that they are seeking a legal opinion as to whether certain of the physicians would be considered authorized to practice medicine by the TEM. The response also appears to indicate that Triple-S believes that the reported overpayments to physicians should be reduced by $783,242, as noted below.

  - For the 3-year period from July 1998 to June 2001, Triple-S stated that they had received documentation for seven provider numbers (3 physicians) relating to $766,477 in reported overpayments. They indicated that they were also requesting evidence of certification from 19 physicians for whom the reported overpayment totaled $1,245,198. According to Triple-S, the reported overpayments of $5,012 related to claims that had been improperly processed and paid to the wrong physicians. Finally, two physicians, one retired and one deceased, accounted for $5,083 in reported overpayments.

  - For the 6-month period from July to December 2001, Triple-S reported that the potential overpayment of $223,128 for seven physicians awaits final

determination once the requested legal opinion is received. According to Triple-S, the reported overpayment of $6,670 for the remaining two physicians falls under a waiver for an extension of the filing period in 2001.

- Unlicensed Ambulance Companies – The response appears to indicate that Triple-S believes that the reported overpayments to ambulance companies should be reduced by $321,156. Specifically, Triple-S commented that the reported $277,998 overpayment to air ambulance companies should be abated because of an ongoing controversy among the licensing authorities. They also noted that they had received documentation from three other ambulance companies, indicating that the reported overpayment should be reduced by $43,158.

- Unlicensed Independent Clinical Laboratories – Triple-S reported that they had no evidence to refute the reported findings. They also commented that they have no control over the CLIA certification dates shown on their system and that they had recently started to request evidence of licensing from clinical laboratories.

The full text of Triple-S's response is presented in Appendix B.

Based on our review of the response to the draft report, our discussions with Triple-S officials about the matters discussed in the response and our evaluation of the additional documentation that Triple-S obtained from the providers after our fieldwork period, we offer the following comments.

- Unlicensed Providers – As we understand it, Triple-S is expressing a concern about the triennial certifications that are issued on preprinted documents that list the entire 3-year licensing period (e.g., July 1998 to June 2001). Nevertheless, Article 5 of TEM regulations as well as both our repeated inquiries of TEM officials and a written ruling by the Executive Director of TEM would all appear to affirm that physicians who do not renew licenses by the filing deadlines will only be certified for the remaining portions of the triennial certification period. Although Triple-S is still awaiting a legal opinion regarding these matters, we are concerned that further delays could result in the application of the administrative finality provisions cited at § 7100.1 of the MCM. We therefore encourage Triple-S to protect the Medicare trust fund by working with the CMS Regional Office to develop an expeditious plan as to the proper course of action to implement until such time as the legal opinion is issued.

    - For the 3-year period from July 1998 to June 2001, we note that the certificates obtained from the three physicians (seven provider numbers) were not in TEM files at the time of our fieldwork and, therefore, appear to have been issued after the filing deadline. Since we were not presented with evidence of the date on which the certification was issued and consistent with existing interpretations of TEM regulations, we consider the evidence obtained by Triple-S both insufficient and inconclusive and the providers improperly paid in the reported amount of

$766,477. Similarly, with respect to the 19 physicians who had been paid $1,245,198, we have not been presented with any evidence of certification; we, therefore, consider the providers to be improperly paid.

Regarding the improperly processed claims totaling $5,012 for four providers, we note that the evidence presented to us indicates that the claims were reprocessed under provider numbers for other members of the same group practices. The evidence, however, did not include medical records that would clearly establish that it was a properly certified member of the group, rather than the unlicensed physician, who had rendered the service.

With respect to the two physicians, one retired and one deceased, who had been paid $5,083, the evidence established that although one physician was not shown as an active physician in the TEM files due to his retirement, he was properly certified during the period when he was still practicing medicine. Consequently, we have revised our original determination to indicate that Medicare payments totaling $4,974 to this physician were proper. We also note that the Medicare payments of $931 to a physician who had died in 1995 would, most likely, never have been issued had Triple-S monitored the provider's certification and updated its files accordingly.

- For the 6-month period from July to December 2001, Triple-S indicated that payments totaling $223,128 to seven physicians cannot be resolved until the above-referenced legal opinion is received. We note, however, that $4,251 of this amount is described as relating to a provider for whom no evidence of certification had been obtained (see Appendix B, Table I, Item 6). As to the other six physicians for whom Triple-S awaits a legal opinion, we reiterate the need to coordinate with the CMS Regional Office to develop a plan to address these concerns until such time as a legal opinion is issued. Regarding the "waiver" of the filing deadline that might apply to two physicians who were paid $6,670, we note that Triple-S has previously informed us that they had closed these provider numbers because certification had not been renewed by the extended deadline. Since that time, we have not been presented with evidence of certification or the date when the licenses were renewed; we, therefore, cannot confirm Triple-S's assertion that these overpayments should be reduced.

In total, we have accepted evidence for one provider and reduced the reported Medicare improper payments from $2,251,565 for 37 physicians to $2,246,591 for 36 physicians.

- Unlicensed Ambulance Companies – Based on our evaluation of Triple-S's response, we consider it inequitable to hold Triple-S or the air ambulance providers accountable to local licensing requirements until the litigation between the Commission and the air ambulance suppliers is settled. We have, therefore, reduced the reported overpayment by $277,998 in payments to three air ambulance suppliers.

For the three ambulance suppliers from whom additional documentation has been received, we note that the documentation presented to us applied either to a different time period or to only certain ambulance units (rather than to all of the units) of the three ambulance companies. Furthermore, in one instance, the evidence indicated neither of the two units of an ambulance company was certified. We, therefore, consider the evidence inadequate and inconclusive as to whether the adjustments proposed by Triple-S are proper.

In total, we have accepted evidence pertaining to three air ambulance companies and reduced the reported Medicare improper payments from $1,525,840 for 25 providers to $1,247,842 for 22 providers.

- Unlicensed Independent Clinical Laboratories - We are pleased to note that Triple-S has recognized the importance of the SARAFS certification and has recently begun to request licensing information from the independent clinical laboratory providers.

APPENDICES

FEDERAL and COMMONWEALTH GUIDELINES

Social Security Act, Title XVIII:

- Section 1861(r)

"*The term 'physician', when used in connection with the performance of any function or action, means (1) a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action…."*

MCM Part 4, Chapter I

- Section 1001

"A physician is a doctor of medicine or osteopathy, dental medicine, dental surgery, podiatric medicine, optometry, or chiropractic medicine legally authorized to practice by the State in which he/she performs such function or action as defined in §1861(r) of the Social Security Act." Underline added.

"Validate information submitted by physicians/health care practitioners/group practices. Verify State licensure with the appropriate State licensing board, and certifications with certification boards. Physicians/health care practitioners eligible for Medicare payment should be licensed/registered by the State in which they provide services. As required by State law, validate all credentials and State licenses/certificates/registrations for all physicians, health care practitioners, and groups receiving a UPIN." Underline added.

FEDERAL and COMMONWEALTH GUIDELINES

Medicare Program Integrity Manual, Chapter 10

- Introduction (Rev. 7, 05-31-01)

"Provider/supplier enrollment is a critical function that attempts to ensure that only qualified and eligible individuals and entities are enrolled in the Medicare program and receive reimbursement for services furnished to beneficiaries. The following instructions apply to the enrollment of any provider and supplier of Medicare services within your jurisdiction, such as physicians and non-physician practitioners, hospitals, and other organizations. Physicians, suppliers, organizations, etc., that wish to be reimbursed for services furnished to Medicare beneficiaries must enroll in Medicare in order to submit claims on behalf of such beneficiaries. If they do not enroll, they cannot receive payments for Medicare covered services." Underline added.

- Section 3.2. Identification E - (Rev. 7, 05-31-01)

"Verify that the applicant is licensed to practice in all States/counties for which a business/practice location is shown. This also includes medical and professional licenses, as well as Federal/State/local business requirements, if applicable. For a non-physician practitioner who is not required to be licensed in the State for whom HCFA has additional requirements, instruct the applicant of the necessary documentation required. Failure to meet the licensing or documentation requirements will result in a denial." Underline added.

TEM Regulations:

- TEM Regulations Article 5 - License Re-certification

"It would be the obligation of all physicians or osteopaths who wish to obtain the re-certification of the license, to register their licenses in the Board of Medical Examiners Professional Registry within the time period provided…" "The non compliance with this requirement will hinder re-certification, and to perform the profession will represent a violation of the law…." (OIG Translation)

FEDERAL and COMMONWEALTH GUIDELINES

Title 42, Code of Federal Regulations:

- 42CFR 410.41(c) – Billing and reporting requirements:

  "(2) Upon a carrier's request, complete and return the ambulance supplier form designated by CMS and provide the Medicare carrier with documentation of compliance with emergency vehicle and staff licensure and certification requirements in accordance with State and local laws."

MCM Part 3, Chapter 2

- Section 2120.1 C - Verification of Compliance

  "The statement must be accompanied by documentary evidence that the ambulance has the equipment required by State and local authorities. Documentary evidence could include a letter from such authorities, a copy of a license, permit certificate, etc., issued by the authorities. The statement and supporting documentation would be kept on file by the carrier." Underline added.

FEDERAL and COMMONWEALTH GUIDELINES

Puerto Rico Department of Health Regulations:

- Public Service Commission and Department of Health Regulation for Ambulance Services dated May 11, 1999

    - Section 4.04 - Definitions

      "Ambulance authorization includes a certificate of need and licenses, rights or privileges provided by the Public Service Commission." (OIG Translation) Underline added.

    - Section 14.04 - Inspections

      "Authorized companies are required to bring their units for inspection annually to the Regional Office of the Public Service Commission and to the Auxiliary Secretariat of the Department of Health." (OIG Translation)

FEDERAL and COMMONWEALTH GUIDELINES

Social Security Act, Title XVIII:

- *Section 1861(s):*

> *"The term 'medical and other health services' means any of the following items or services:"*
> *"(3) … diagnostic laboratory tests, and other diagnostic tests;"*
> …
> *"No diagnostic tests performed in any laboratory… shall be included within paragraph (3) unless such laboratory--*
> *(16) if situated in any State in which State or applicable local law provides for licensing of establishments of this nature, (A) is licensed pursuant to such law.…"*

MCM Part 3, Chapter 2

- Sections 2070.1 and 2070.1 C:

> *"Independent Laboratories. --Diagnostic laboratory services furnished by an independent laboratory are covered under medical insurance if the laboratory is an approved Independent Clinical Laboratory."*
>
> *"An approved independent clinical laboratory is one which is approved by the Secretary of Health, Education, and Welfare as meeting the specific conditions for coverage under the program. These require that: (l) where State or applicable local law provides for licensing of independent clinical laboratories, the laboratory is either licensed under such law or it is approved as meeting the requirements for licensing laboratories; and (2) such laboratories also meet the health and safety requirements prescribed by the Secretary of Health, Education, and Welfare. See 'Conditions for Coverage of Services of Independent Laboratories'."* Underline added.

FEDERAL and COMMONWEALTH GUIDELINES

State Operations Manual, Chapter 6

- Special Procedure for Laboratories

> *"Section 6141 of the Omnibus Budget Reconciliation Act of 1989, Public Law 101-239, requires that laboratories participating in the Medicare program comply with CLIA requirements. Therefore, all laboratories, with the exception of laboratories licensed by a State with a HCFA-approved State laboratory licensure program (CLIA-exempt laboratories) must obtain a CLIA certificate to operate and to be eligible for payment under Medicare and Medicaid. Although CLIA-exempt laboratories do not need a CLIA certificate to operate, they are assigned a CLIA identification number for Medicare and Medicaid payment purposes."* Underline added.

Puerto Rico Department of Health Regulations:

- Department of Health Regulation No. 92, Public Act 170 dated August 12, 1988

SARAFS Regulation for the Operation of Clinical Laboratories and Blood Banks

Chapter 2 – Licenses

"No entity or person can establish or operate in Puerto Rico a clinical laboratory, anatomical pathology laboratory and/or blood bank without previously obtaining a license issued by the Puerto Rico Department of Health." (OIG Translation)

VP-10 (CF)

MEDICARE
Part-B Carrier
Bene. PR & USVI 1-800-981-7015
Prov. PR & USVI 1-877-715-1921
TDD/TTY - 787-782-5430

January 17, 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: Common Identification Number A-02-02-01014

Dear Mr. Horgan:

This is in response to your letter dated December 13, 2002[1]; regarding the Office of Inspector General Office of Audit Services' draft report entitled "Review of Unlicensed Providers in Puerto Rico".

The following is our response regarding the results presented by the OIG auditors in their report. Please note that our responses are in the same order that were presented in the formal document submitted by OIG.

Unlicensed providers

According to the report submitted, the review conducted under this subject presented that there were 37 physicians that were not authorized to practice medicine in Puerto Rico. This conclusion was based on the triennial certification issued by the Board of Medical Examiners (TEM by the Spanish acronym). Based on our experience with the manner in which the TEM issues the triennial certifications and the different point of view regarding the applicable law, we respectfully disagree with OIG's conclusions.

Due to these controversies, we have requested a legal opinion from the Puerto Rico Secretary of Health who oversees the functions of the TEM. Once the response is received, this Contractor will discuss the issues with CMS representatives from the New York Regional Office and will proceed to take the necessary steps to address the situation.

However, should the overpayment prevail, adjustments shall be made based upon the reasons indicated below.

[1] Please be advised that a request for extension to answer this report was granted by OIG.

OIG Note: Triple-S's response, dated January 17, 2003 was received by OIG on February 20, 2003.

Unlicensed Ambulance Companies

Regarding the unlicensed ambulances, both the OIG and this Contractor agreed that the potential overpayment calculated by OIG should be reduced from $1,525,842 to $1,247,843. The reason for such reduction is the following:

- The audit covered a period of three years, 1998-2001. During that period there was a new law/regulation in Puerto Rico requiring air ambulances to be certified by the Department of Health. However, as of today there is still a controversy in relation to the air ambulance certification, reason for which the Department of Health has not yet certified any of such ambulances. In view of the above, we applied the content of Section 4.2, Chapter 10 of the Program Integrity Manual, regarding the utilization of the Valid Charter Flight License (FAA Part 135 Certificate) and until the local issue is resolved the provider number will remain active and the procedure will be to request the FAA certification. As a result of this situation, OIG has agreed with this Contractor.

- In addition after the OIG fieldwork was completed, this Contractor received documentation for three (3) ambulance companies. This overpayment will be reduced by a total of $43,158. (Please note that this amount has not been adjusted in the total presented in Table II.)

Unlicensed Independent Clinical Laboratories

The issue regarding the unlicensed independent clinical laboratories brings us various concerns. At this point, we do not have evidence at hand to oppose the overpayment identified by OIG; therefore, we will not argue the amounts identified. Nevertheless, we are investigating the following concerns:

- We do not have control over the effective dates of the CLIA certification shown in the system. Therefore, once CMS has updated the system, claims should be automatically denied if the clinical laboratory is not properly certified.

- We started requesting the Puerto Rico local licenses to the clinical laboratories last year. Although the local license is supposed to be renewed on a yearly basis, we have been advised that, in some instances, the local authorities evaluates laboratory providers every two years, together with the evaluation they perform for CMS for the purpose of CLIA recertification.

OIG Note: A physician may have more than one provider number in Triple-S's system. The statistics reported by OIG refer to the number of unlicensed physicians. The statistics cited by Triple-S above, however, refer in some instances to the number of physicians (providers) and in other instances to provider numbers. To clarify the matter, we offer the following explanations: the first bullet refers to 19 physicians (21 provider numbers); the second bullet refers to seven provider numbers (three physicians); the third bullet refers to four provider numbers (four physicians) and the last bullet refers to two physicians (two provider numbers), for a total of 28 unlicensed physicians discussed in the draft report. For further details, please see Appendix C, which reconciles the statistics and dollar amounts above to Table I of this response.

Management response to the recommendations made by OIG

Following the same order presented by OIG, our response to their recommendation is the following:

- From the recommendation presented in the CFO Audit performed over this contractor in Year 2000, enhancement has been made to closely monitor the provider enrollment process. An evidence of these enhancements was stated by OIG as part of their conclusion in their report.

- We will be contacting CMS Regional Office to establish the Protocol for the recoupment of the corresponding overpayment.

- We will reinitiate the communication with the Department of Health and TEM to try to obtain the information electronically so we can develop a system to handle the request of certifications and documents. Some difficulties have been experienced in the past regarding similar initiatives. But taking into consideration that the government is enhancing their technological solutions to provide better services, we look forward to explore alternatives with them.

Should you have any questions regarding this response or need additional information, please call me at (787) 749-4083.

Cordially,

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

TABLE I
page 1 of 2

	Physicians for the Period of July 1998 through June 2001	
Item	Medicare Payments	Carrier's Response
1	$30,216	Carrier will request the proper documentation from the provider
2	3,147	Carrier will request the proper documentation from the provider
	41,190	Carrier will request the proper documentation from the provider
	14,328	Carrier will request the proper documentation from the provider
3	0	After the OIG fieldwork was completed, the certification obtained indicated that the provider was certified until March 31, 2001, date in which he retired.
4	0	Claims were billed under an incorrect provider number. As a result an adjustment has been performed to correct the situation and a zero overpayment should be presented for the provider identified by OIG.
5	0	Carrier has identified that this provider has passed away
6	53,183	Carrier will request the proper documentation from the provider
7	241	Carrier will request the proper documentation from the provider
8	0	Claims were billed under an incorrect provider number. As a result an adjustment has been performed to correct the situation and a zero overpayment should be presented for the provider identified by OIG.
9	4,873	Carrier will request the proper documentation from the provider
10	12,060	Carrier will request the proper documentation from the provider
11	48,439	Carrier will request the proper documentation from the provider
12	32	Carrier will request the proper documentation from the provider
13	0	Data entry error occurred; a letter suffix was enterly incorrectly. As a result an adjustment has been performed to correct the situation and a zero overpayment should be presented for the provider identified by OIG
14	39,911	Carrier will request the proper documentation from the provider
15	622	Carrier will request the proper documentation from the provider
16	123,931	Carrier obtained documentation after OIG fieldwork was completed
	121,801	Carrier obtained documentation after OIG fieldwork was completed
	18,411	Carrier obtained documentation after OIG fieldwork was completed
	155,686	Carrier obtained documentation after OIG fieldwork was completed
	8,228	Carrier obtained documentation after OIG fieldwork was completed
17	28,991	Carrier will request the proper documentation from the provider
18	308,084	Carrier will request the proper documentation from the provider
19	3,763	Carrier will request the proper documentation from the provider
20	120,037	Carrier will request the proper documentation from the provider
21	186,231	Carrier obtained documentation after OIG fieldwork was completed
22	0	Claims were billed under an incorrect provider number. As a result an adjustment has been performed to correct the situation and a zero overpayment should be presented for the provider identified by OIG.
23	215,790	Carrier will request the proper documentation from the provider
24	34	Carrier will request the proper documentation from the provider
25	225,927	Carrier will request the proper documentation from the provider
26	94,287	Carrier will request the proper documentation from the provider
27	43	Carrier will request the proper documentation from the provider
28	152,185	Carrier obtained documentation after OIG fieldwork was completed
	$2,011,671	

TABLE I
page 2 of 2

Physicians for the Period of July 2001 through December 2001

Item	OIG Determination	Carrier's Response
1	$45	A waiver was granted by the PR-TEM until Sept.30, 2001. The overpayment identified was $0
2	38,958	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
	7,046	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
	24,786	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
	2,401	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
3	10,130	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
4	42,912	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
5	6,626	A waiver was granted by the PR-TEM until Sept.30, 2001. The overpayment identified after this period was $3,288
6	4,251	Certification evidence not documented by the Carrier/No certification evidence at the TEM
7	1,226	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
8	87,453	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
9	3,965	Carrier is awaiting legal opinion from the Puerto Rico Secretary of Health
	$229,799	

TABLE II

Ambulance Suppliers for the Period of July 1998 through December 2001

OIG Determination	Carrier's Response
3,196	Carrier agrees with OIG
496	Carrier agrees with OIG
118,553	Carrier agrees with OIG
135,010	Carrier agrees with OIG
20,181	Carrier agrees with OIG
110	Carrier agrees with OIG
105,634	Carrier agrees with OIG
15,980	Carrier agrees with OIG
35,897	Carrier agrees with OIG
59,954	Carrier agrees with OIG
0	OIG agrees with Carrier
0	OIG agrees with Carrier
0	OIG agrees with Carrier
38,118	Carrier provided certification evidence with a later expiration date (10/16/01). No further evidence was available. OIG agrees to adjustment made by Carrier.
242,076	After the OIG fieldwork was completed, the Carrier obtained a copy of the certification which resulted in the reduction of the overpayment to the amount of $4,246
6,472	Carrier provided certification evidence with an earlier expiration date (10/22/00). No further evidence was available. OIG agrees to adjustment made by Carrier.
70,676	After the OIG fieldwork was completed, the Carrier obtained a copy of the certification which resulted in the reduction of the overpayment to the amount of $37,847
278,567	Evidence from Carrier covers a period prior (8/25/99-8/25/00) to the period identified by OIG. OIG adjusted excluding from 8/10/00 to 8/25/00.
1,970	Evidence from Carrier covers a period subsequent (3/26/01-3/26/02) to the period identified by OIG which results in the reduction of the overpayment to the amount of $1,065
10,265	Evidence submitted by Carrier pertains to other providers with similar name (Prov. w unit# cert 2/12/01-02; Prov. w u# cert 12/00-01) Provider has 2 units and under .[1]
20,234	Carrier submitted endorsement letter which is the initial stage in the process/Not considered a certification by Commonwealth.
10,204	Carrier submitted endorsement letter which is the initial stage in the process/Not considered a certification by Commonwealth.
34,228	Carrier submitted endorsement letter which is the initial stage in the process/Not considered a certification by Commonwealth.
2,604	Carrier submitted endorsement letter which is the initial stage in the process/Not considered a certification by Commonwealth.
37,419	Carrier submitted Public Service Commision checklist inspection which is the initial stage in the process/Not considered a certification by Commonwealth.
$1,247,843	

[1] Provider and ambulance unit numbers redacted by OIG.

Reconciliation, Auditee Response to Tables I and II

Physicians, July 1998 to June 2001

Carrier will request proper documentation:

Provider #s	Physicians	Item	Payments
1	1	1	$30,216
2	2	2	3,147
3			41,190
4			14,328
5	3	6	53,183
6	4	7	241
7	5	9	4,873
8	6	10	12,060
9	7	11	48,439
10	8	12	32
11	9	14	39,911
12	10	15	622
13	11	17	28,991
14	12	18	308,084
15	13	19	3,763
16	14	20	120,037
17	15	23	215,790
18	16	24	34
19	17	25	225,927
20	18	26	94,287
21	19	27	43
		Sub-Total	$1,245,198

Carrier obtained documentation after OIG fieldwork:

Provider #s	Physicians	Item	Payments
1	1	16	$123,931
2			121,801
3			18,411
4			155,686
5			8,228
6	2	21	186,231
7	3	28	152,185
		Sub-Total	$766,474
		Sub-Total	$ 2,011,671

Provider numbers incorrectly keyed/Carrier adjusted:

Provider #s	# of Physicians	Item	Medicare Payments Original	Medicare Payments per Table I
1	1	4	$931	0
2	2	8	80	0
3	3	13	40	0
4	4	22	3,961	0
			$5,012	0

Other miscellaneous issues:

Provider #s	# of Physicians	Item	Medicare Payments per Draft Report	Medicare Payments per Table I
1	1	3	$4,974	0
2	2	5	109	0
			$5,083	0

Total	$2,021,766

Physicians, July 2001 to December 2001

Carrier awaiting legal opinion:

Provider #s	Physicians	Item	OIG Determination
1	1	2	38,958
2			7,046
3			24,786
4			2,401
5	2	3	10,130
6	3	4	42,912
7	4	6	4,251
8	5	7	1,226
9	6	8	87,453
10	7	9	3,965
		Sub-Total	$223,128

Waiver by Secretary of Health

Provider #s	Physicians	Item	OIG Determination
1	1	1	$45
2	2	5	6,626
		Sub-Total	$6,670
		Total	$229,799

	Provider #s	Physicians
July 1998 to June 2001:		
Requesting documentation:	21	
Obtained documentation later:	7	
July to December 2001:		
Awaiting legal opinion:		7
Waiver by Secretary of Health:		2
	28	9
	-28	28
"Unlicensed Providers"		37

Ambulance Suppliers, July 1998 to December 2001

Ground Ambulance Not Licensed:

Item	Original Determination	Revised Determination
1	$3,196	$3,196
2	496	496
3	118,553	118,553
4	135,010	135,010
5	20,181	20,181
6	110	110
7	105,634	105,634
8	15,980	15,980
9	35,897	35,897
10	59,954	59,954
14	38,118	38,118
16	6,472	6,472
18	278,567	278,567
20	10,265	10,265
21	20,234	20,234
22	10,204	10,204
23	34,228	34,228
24	2,604	2,604
25	37,419	37,419
	$933,121	$933,121

Air Ambulance Suppliers:

Item	Original Determination	Revised Determination
11	$137,145	$0
12	18,237	0
13	122,616	0
	$277,998	$0

Partial Documentation Received:

	Original Determination	Revised Determination	Carrier Reduction
15	$242,076	$242,076	$4,246
17	70,676	70,676	37,847
19	1,970	1,970	1,065
	$314,722	$314,722	$43,158

	Original Determination	Revised Determination
Ground Ambulance	$933,121	$933,121
Air Ambulance	277,998	0
Partial Documentation	314,722	314,722
Total	$1,525,841	$1,247,843

[redacted]

This report was prepared under the direction of Timothy J. Horgan. Other principal Office of Audit Services staff who contributed include:

Elliot Hirshon, *Audit Manager*
Margie Colon, *Senior Auditor*
Pedro Rodriguez, *Auditor*