DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL
REGION II

Memorandum

Date : February 21, 2003

From : Regional Inspector General
for Audit Services

Subject: Review of the Do Not Forward Initiative – Report Number A-02-02-01023

To Gilbert Kunken
Acting Regional Administrator
Centers for Medicare & Medicaid Services, Region II

Attached are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General's report entitled "Review of the Do Not Forward Initiative." We audited the accounting controls and processes for recording and reporting expenses, related liabilities and cash expenditures for checks returned or withheld from Medicare providers under the "Do Not Forward (DNF) Initiative". The audit was undertaken due to preliminary indications from CFO audits that Medicare contractors were not properly recording DNF activity on their financial reports. Our review included examinations of DNF activity at each of the four Region II Medicare carriers.

Officials in your office have generally concurred with our recommendations, set forth on page 7 of the attached report and have taken, or agreed to take, corrective action. We appreciate the cooperation given us by both the Medicare contractors and also by your office in this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me.

To facilitate identification, please refer to Report Number A-02-02-01023 in all correspondence relating to this report.

Timothy J. Horgan

Attachments - as stated

cc: Peter Reisman, CMS Region II

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE DO NOT FORWARD INITIATIVE

JANET REHNQUIST
Inspector General

FEBRUARY 2003
A-02-02-01023

Office of Inspector General

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Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
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February 21, 2003

Our Reference: Common Identification No. A-02-02-01023

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

Dear Mr. Kunken

This report provides you with the results of our "REVIEW OF THE DO NOT FORWARD INITIATIVE".

The objective of this review was to evaluate the accounting controls and processes for recording and reporting expenses and the related liabilities and cash expenditures for checks returned or withheld under the "Do Not Forward (DNF) Initiative". The audit included examinations of DNF activity at each of the four Region II Medicare carriers in order to assure that the carriers' financial reports were correctly stated.

This review identified system limitations and weaknesses in the carriers' implementation of the Centers for Medicare & Medicaid Services (CMS)[1] guidelines that require corrective actions in order to prevent misstatement of the CMS financial reports. The results of our review indicate that each of the four Region II carriers were misstating their CMS financial reports with respect to their DNF activity.

These misstatements, totaling $4,845,530, affected several accounts in the contractors' financial reports. The results also indicated that the nature of the misstatement was generally related to the claims processing system used by the carrier.

We are recommending that the CMS Regional Office work with its Region II contractors to effectively implement the DNF guidelines, assure that the total misstatements of the financial reports have been properly resolved, and follow up with the contractors to ensure that their financial reports are accurately prepared.

[1] The Centers for Medicare & Medicaid Services were formerly known as the Health Care Financing Administration (HCFA).

Finally, the review identified limitations in shared systems regarding the recording of DNF activity; this matter has been referred to the CMS Central Office for further consideration.

The CMS Regional Office concurred with the recommendations to ensure corrective actions by the Region II contractors. The full text of the CMS response is attached to this report as Appendix B.

INTRODUCTION

Background

The CMS is the largest purchaser of health care in the world. The Medicare program, which accounted for 17 cents of every dollar spent on health care in the United States in 2000, provides insurance to people age 65 and over, people with end-stage renal disease, and certain people with disabilities.

The CMS administers the Medicare program by contracting with private organizations, known as fiscal intermediaries (FI) and carriers, to process and pay claims for Medicare services. The contractors (i.e., FIs and carriers) report their financial activity to CMS through several means, including the quarterly "Contractor Financial Reports – Statement of Financial Position" (Form CMS-750) and the "Monthly Contractor Financial Report" (Form CMS-1522).

- The CMS-750 is designed to provide a method for reporting financial activities for a contractor's Medicare benefit payments. Contractors are instructed to prepare the CMS-750 using the accrual basis of accounting and double entry bookkeeping. For example, amounts for Medicare claims adjudicated but not yet paid at the end of a quarter should be recorded as "Operating/Program Expense" and "Accounts Payable" in order to assure that the CMS financial statements are properly stated.

- The CMS-1522 is designed to report the "Total Funds Expended" (TFE) for Medicare benefits per the contractor's records and to reconcile the TFE to the Federal funds drawn during the month. The form is also used to reconcile the TFE and funds drawn to amounts reported by the contractor's bank.

The DNF Initiative was initially implemented for Durable Medical Equipment Regional Carriers (DMERC) in February 1997 to preclude the forwarding of Medicare checks to locations other than the address of record on Medicare provider files. The initiative was expanded to all carriers effective July 1, 2000, to FIs using the Arkansas shared system effective July 1, 2002 and is expected to be initiated at FIs using the Fiscal Intermediary Shared System in the near future. To accomplish the initiative, CMS prescribes the use of "Return Service Requested" envelopes to permit the U.S. Postal Service to return Medicare checks to contractors at no cost.

The CMS instructions to carriers and FIs subject to the DNF Initiative provide that:

- Any new address indicated by the U.S. Postal Service is not automatically used to update the Medicare provider file or to remail the check; instead, the provider must submit an original, signed notification of the appropriate address for both Medicare payments and for any other Medicare correspondence;
- Any returned checks must be logged, accounted for and immediately cancelled by the contractor's financial staff until the proper address is updated and verified, and
- Upon receipt of a returned check, the carrier or FI (or, in the case of DMERCs, the National Supplier Clearing House [NSC]) annotates the provider file with a DNF flag to prevent further payments until the address is verified. Therefore, any subsequent claims for the flagged provider are processed for adjudication only with no check issued until an authorized address correction is processed and the DNF flag is removed.

In addition to the claims processing controls discussed above, CMS has issued guidance related to the financial accounting for DNF activities in the Medicare Carriers Manual, Program Memoranda and through periodic discussions with its contractors. For example, this guidance requires that contractors void returned checks and report them on the CMS-750 as "Other Liabilities" until one year after the date of issuance; this accounting treatment would also increase the ending cash balance on the CMS-750. After one year, the CMS instructions provide that the returned check should be cancelled; at this point in time, both the expense and the liability would be reduced.

With respect to subsequent claims that are adjudicated but not paid, the CMS instructions indicate that, "Extreme care must be taken for all claims which have been 'approved for payment but not paid' at the end of a quarter.... The dollar totals should be checked to make certain that **all** claims that have been approved for payment and have not been paid are included in the total... payable." Similarly, these guidelines require that the reported benefits costs include both the cash outlays and the accrued liabilities. Finally, under draft instructions issued in October 2001, carriers would be instructed to cancel these payments after one year. At that time, both the expense and the liability would be reduced.

The standard shared Medicare systems used by contractors subject to the DNF Initiative should generate statistics regarding the number of providers, number of checks and total dollars related to DNF activity. The two standard processing systems used by the Medicare carriers and the DMERC in Region II are the Multiple Carrier System (MCS) and the ViPS Medicare System (VMS)[2]. Both of these systems presently produce reports which account for the financial effects of DNF items; however, neither of the systems can properly post certain DNF items as expenses and liabilities. To assure that the financial reports are properly stated, therefore, Region II contractors may have to employ alternative measures to overcome the limitations of the shared systems. Accordingly, a listing of the shared system reports which have proved useful in reporting DNF activity is included as Appendix A to this report. In this regard, however, it is important to note that implementation of the Healthcare Integrated General Ledger Accounting System

[2] ViPs is also known as Viable Information Processing Systems.

(HIGLAS) by MCS is scheduled to begin in July 2002 with phased implementation after site testing is completed. Among the functions envisioned for HIGLAS for MCS are CFO Reporting, Check Functions for Void and Stale Dated Checks, and Accounts Payable Functions for Returned Checks and Do Not Forward Checks.

Objectives, Scope and Methodology

The objective of this audit was to evaluate the accounting controls and processes for recording and reporting expenses and the related liabilities and cash expenditures for DNF Checks by Region II Medicare carriers in order to assure that the carriers' financial reports (i.e., CMS-750 and CMS-1522) were correctly stated in accordance with the Chief Financial Officers Act of 1990.

The review included examinations of DNF activity at each of the Region II Medicare carriers and of the DNF activity recorded from the shared systems used by these contractors, as follows:

MCS:

- Empire Medicare Services and
- HealthNow

VMS:

- Empire Medicare Services;
- Group Health Incorporated;
- HealthNow, and
- Seguros de Servicios de Salud de Puerto Rico.

To accomplish the audit objective, we:

- reviewed the applicable laws, regulations and guidelines,
- obtained an understanding of each carrier's procedures and controls for the recording of DNF activity on the CFO reports[3],
- obtained and reviewed supporting documentation (e.g., MCS and VMS system reports, the CMS-750 and CMS-1522) from the carriers in order to determine the accuracy of the reporting of DNF activity on the CFO reports, and
- reviewed the findings with carrier officials to assure the accuracy and objectivity of the facts presented to CMS.

Our review of the accounting controls and processes was limited to matters concerning the recording and reporting of DNF returned checks and withholds on the CMS-750 and CMS-1522.

[3] For purposes of this report, the term "CFO reports" is limited to the CMS-750 and the CMS-1522.

The audit period, with the exception of pilot testing of one shared system at one contractor for the quarter ended March 31, 2001, was the most recent calendar quarter for which the carrier had filed CFO reports (quarter ending December 31, 2001) at the time of our field work.

Field work was performed in the month of March 2002 at the offices of Region II contractors located in Binghamton, New York; New York City; San Juan, Puerto Rico and Syracuse, New York. This audit was conducted in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

The review identified system limitations and weaknesses in the carriers' implementation of CMS guidelines that require corrective actions in order to prevent misstatement of the CMS financial reports. As previously noted, the Medicare carriers and the DMERC in Region II use two different standard processing systems, MCS and VMS. We also note that some of these Region II contractors use only one of the two systems while others use both systems.

The results of our review at the four Region II carriers identified misstatements in the CFO reports with respect to the DNF activity at each of the contractors and with respect to reports prepared from both of the standard processing systems. These misstatements, totaling $4,845,530, affected several accounts in the CMS-750 and CMS-1522 reports, as detailed below.

Shared System	CMS-750 Understated/(Overstated):				CMS-1522 Overstated:	Combined
	Expense	Cash	Liability	Total	TFE	Total
MCS	($62,851)	$342,137	$279,286	$558,572	$342,137	$900,709
VMS	1,910,942	40,979	1,951,921	3,903,842	40,979	3,944,821
	$1,848,091	$383,116	$2,231,207	$4,462,414	$383,116	$4,845,530

The results indicated, however, that the nature of the misstatements was generally related to whether the contractor was basing its reports on the MCS or the VMS system, as explained below.

The MCS properly records withheld checks but cannot cancel or void DNF returned checks.

Two Region II Medicare contractors use the MCS. At both contractors, the "Total Funds Expended" were overstated on the CMS-1522 because of system limitations with regard to the processing of DNF returned checks. In effect, the system limitation treats DNF returned checks as outstanding items rather than as voided checks. Therefore, DNF returned checks were

reported as funds expended, overstating the TFE on the CMS-1522 by $342,137 at these MCS contractors. In addition to the effect on TFE as reported on the CMS-1522, both contractors misstated balances on the CMS-750, as discussed below.

- One contractor was not aware of the CMS guideline which requires that returned checks must be recorded as a liability on the CMS-750. Consequently, in the absence of contractor action to address the MCS limitations, the cash and liabilities on the CMS-750 were understated by the same amount as TFE was overstated on the CMS-1522.

- Another contractor, responding to the CMS requirement to record the liability for returned DNF checks, prepared a journal entry to post "Benefits Expense" and "Other Liabilities". This entry properly recorded the liability, but understated the cash balance, overstated the expense (which had already been recorded when the claim was processed) and did not resolve the fact that TFE was overstated.

The VMS properly records returned checks but does not record DNF withheld checks on the CFO reports.

Four Region II Medicare contractors use the VMS. For each of these contractors, the checks withheld under the DNF Initiative were not reported on the CMS-750 as a result of oversights by the contractors.

Both the "Benefits Expense" and "Other Liabilities" for three of the contractors were understated by the amount of the DNF withholds. These contractors were either not aware that the DNF withholds should be reported as expenses and liabilities on the CMS-750, or they thought that the DNF items were being reported as expenses and liabilities on their CMS-750. These contractors have informed us that, as a result of our review, they have taken corrective action to ensure that the CMS-750 will accurately reflect an expense and liability for DNF withholds.

Although no funds or cash were expended for amounts withheld under the DNF Initiative, the fourth contractor included DNF withholds on the CMS-1522 as TFE. As a result of treating these withheld payments as a component of TFE, the contractor understated both the cash and liabilities on the CMS-750. In this instance, the contractor had accumulated information from several different sources to prepare the CMS-1522; however, in so doing, they did not take care to exclude the DNF withholds from the TFE. The resulting journal entry improperly recorded DNF withholds as cash disbursements and funds expended; instead, these items should have been recorded as liabilities.

Conclusion

The CMS has issued guidelines on the reporting of financial activity related to the DNF initiative to the Medicare contractors through program manuals and several program memoranda. In addition, these matters have been the subject of periodic telephone conferences between CMS and the Medicare contractors. This review of Region II contractors' compliance with these guidelines, however, indicates the need for additional communications to assure that the contractors report their DNF activity properly on the CFO reports.

As previously reported, the misstatements related to limitations of the shared claims processing systems used by the Region II Medicare contractors. Since contractors outside of Region II also use these claims processing systems, we have advised the CMS Central Office that corrective actions may be needed to resolve the present system limitations.

Recommendations

We recommend that the CMS Regional Office:

- work with the Region II contractors to effectively implement the CMS guidelines pertaining to the DNF returned checks, the amounts withheld under the DNF Initiative and the cancellation of DNF expenses and liabilities after one year,

- assure that the total misstatements of the CMS-750 (totaling $4,462,414) and the CMS-1522 (totaling $383,116) have been properly resolved, and

- follow up with the contractors to ensure that their financial reports correctly report their DNF activities.

OTHER MATTERS

In addition to our examination of the financial data relating to the DNF initiative, we inquired of the Region II contractors as to their ability to meet the current and proposed guidelines on cancellation of DNF expenses and liabilities after one year.

With respect to these matters, we note that some of the Region II contractors informed us that they would find it difficult to write off the DNF liabilities after one year. In certain instances, contractors also reported that at the present time, they lack clear guidance from CMS regarding the cancellation of DNF returned checks or withholds. We also found that, in general, the contractors are not canceling these liabilities after one year. If the contractors are not canceling the DNF expenses and liabilities after one year, the amounts on the CMS-750 could be misstated.

CMS Regional Office's Comments

The CMS Regional Office, in its response dated January 22, 2003, concurred with the recommendations and requested additional information in order to ensure corrective actions by the Region II contractors. The full text of the CMS response is attached to this report as Appendix B.

Office of Audit Services' Response

We have provided the CMS Regional Office with the additional information requested and will provide any other documents that the CMS may need to ensure corrective actions by the Region II contractors.

APPENDICES

System Reports Used by Region II Contractors to Capture DNF Activity in CMS Financial Reports

	Returned Checks	Withheld Checks
MCS System	HBDR0975	HBDR0975
VMS System	260 Report	Carriers may use DN1001 or FR41001; DMERCs use FR41001

APPENDIX B

Region II

MEMORANDUM

Date: January 22, 2003

From: Gilbert Kunken
Acting Regional Administrator

To: Timothy J. Horgan
Regional Inspector General for Audit Services

Subject: Response to Draft Report, Common Identification Number: A-02-02-01023, Review Of The Do Not Forward Initiative.

The New York Regional Office of CMS agrees with your general conclusion that additional communications are necessary to assure that the contractor's report their DNF activity properly on the CFO reports. The accuracy of the CMS-750 and CMS-1522 are important and are receiving an increasing review and oversight by our office. Contractor compliance with the DNF guidelines is inherent to the accuracy of these reports.

In order for us to take corrective action with the Region II contractors, we ask that you provide us with documentation identifying the $4,462,414 of misstatements on the CMS-750 by individual contractor. Similarly, we need identification by contractor for the $383,116 misstated on the CMS-1522. Once we have this information, we will contact the contractors to implement corrective actions and to reinforce the proper reporting requirements. We believe that the recommended contractor education and communication will be a useful measure to prevent recurrences of this problem.

Thank you for the opportunity to comment on the draft report. If you would like to discuss these issues with us, please contact Sandra Tokayer at extension 4-2505.

ACKNOWLEDGMENTS

This report was prepared under the direction of Timothy J. Horgan, Regional Inspector General for Audit Services. Other principal OAS staff included:

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