DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

FEB 19 2004

TO: Dennis G. Smith
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: Review of Payments Made by Palmetto Government Benefits Administrators for Home Health Services Preceded by a Hospital Discharge (A-04-03-00018)

We are alerting you to the issuance of the subject report within 5 business days from the date of this memorandum. A copy of the report is attached.

The objective of the audit was to determine whether home health agencies (HHA) properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals. Our audit period covered paid claims with HHA dates of service from October 1, 2000 through September 30, 2001 (fiscal year (FY) 2001).

Home health intermediaries process claims and conduct audits of cost reports submitted by HHAs. Palmetto, one of four regional home health intermediaries, processes Medicare claims and conducts audits of cost reports submitted by 3,500 HHAs in 16 States.

We identified 29,249 HHA claims for which there was an inpatient hospital discharge within 14 days preceding the home health services. From a statistically valid sample of 199 of these claims, we identified overpayments to HHAs totaling $57,861. The claims should have been paid at a lower rate, but were not because HHAs did not accurately complete the required Outcome and Assessment Information Set (OASIS) for these beneficiaries.

Under the prospective payment system for home health services in effect since 2000, each HHA must, as a condition of participation in Medicare, provide every patient a comprehensive assessment of his or her health status. This assessment must incorporate OASIS data (42 CFR § 484.55). Information reported on OASIS is used to compute a payment group, which in turn, determines the amount of Medicare reimbursement.

One data element required by OASIS is whether a beneficiary has been discharged from an acute care inpatient facility within the last 14 days. The Centers for Medicare & Medicaid Services (CMS) determined that an acute care hospital discharge (without a followup postacute inpatient stay) within the 14 days immediately preceding admission to home care is associated with the lowest costs during a 60-day service period. Accordingly, CMS designed the Home Health Resource Groups to provide for a lower payment for HHA services rendered to

beneficiaries discharged from an acute care hospital within the 14 days immediately preceding admission to home health care.

Overpayments occurred because HHAs had not established the necessary controls to identify all inpatient stays and so prevent the incorrect billing for services. In addition, Palmetto did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

We estimate that Palmetto made approximately $10 million in overpayments for 29,249 claims.

We recommended that Palmetto:

- recover the $57,861 in overpayments for the claims in the sample,

- review the balance of the universe to identify and recover additional overpayments (we estimate the total overpayments to be $10,043,328),

- conduct postpayment data analysis, subsequent to the period of the audit, to detect improperly paid HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions as necessary, and

- provide education to HHAs to ensure that beneficiary discharge data is completed accurately on the patient assessment instruments.

In a letter dated August 29, 2003, Palmetto said in response to our draft report that the home health prospective payment system was a new system during the period of review and that education efforts since may have reduced such errors. Palmetto indicated, too, that it might not have access to all relevant hospital stay information. Details of Palmetto's comments are discussed after the Recommendations section of this report and included in their entirety in Appendix C. Since submission of Palmetto's comments, CMS published a transmittal specifically to address the home health "payment vulnerability that [the] OIG has identified" in this and three companion reports (Transmittal 13 (Publication 100-04 – Medicare Claims Processing), Change Request 2928, dated October 24, 2003). The transmittal sets forth payment safeguards (both prepayment and postpayment) to be instituted by CMS and its regional home health intermediaries to detect prior hospital stays and ensure that Medicare pays at the correct payment level.

If you have any questions or comments about this report, please do not hesitate to call me or have your staff call George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Charles J. Curtis, Regional Inspector General for Audit Services, at (404) 562-7750. To facilitate identification, please refer to report number A-04-03-00018 in all correspondence relating to this report.

Attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

FEB 20 2004

Report Number: A-04-03-00018

Mr. Bruce Hughes
Executive Vice President and Chief Operating Officer
Palmetto Government Benefits Administrators
Post Office Box 100134
Columbia, South Carolina 29202

Dear Mr. Hughes:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Payments made by Palmetto Government Benefits Administrators for Home Health Services Preceded by a Hospital Discharge." A copy of this report will be forwarded to the action official below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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, OIG reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise (see 45 CFR part 5). As such, within 10 business days after the final report is issued, it will be posted on the Internet at http://oig.hhs.gov.

To facilitate identification, please refer to report number A-04-03-00018 in all correspondence.

Sincerely yours,

Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV

Enclosures - as stated

Direct Reply to HHS Action Official:
Ms. Rose Crum-Johnson
Region IV Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
61 Forsyth Street, S. W. 4T20
Atlanta, Georgia 30303-8909

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF PAYMENTS MADE BY PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS FOR HOME HEALTH SERVICES PRECEDED BY A HOSPITAL DISCHARGE

FEBRUARY 2004
A-04-03-00018

EXECUTIVE SUMMARY

OBJECTIVE

The objective of the audit was to determine whether home health agencies (HHA) properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals. Our audit period covered paid claims with HHA dates of service from October 1, 2000 through September 30, 2001 (fiscal year (FY) 2001).

SUMMARY OF FINDINGS

We identified 29,249 HHA claims for which there was an inpatient hospital discharge within 14 days preceding the home health services. From a statistically valid sample of 199 of these claims, we identified overpayments to HHAs totaling $57,861. The claims should have been paid at a lower rate, but were not because HHAs did not accurately complete the Outcome and Assessment Information Set (OASIS) for these beneficiaries in accordance with 42 CFR § 484.

As a condition of Medicare participation, HHAs are required to complete a comprehensive assessment for each patient. As part of the assessment, the HHA must accurately complete OASIS using the language and groupings as specified by the Secretary (42 CFR § 484.55). OASIS includes a data element requiring the HHA to identify all inpatient facilities from which the patient was discharged in the 14 days prior to starting home care. As published in the Federal Register on July 3, 2000, the Centers for Medicare & Medicaid Services (CMS) explained that "Our data indicate that an acute care hospital discharge (without follow up post-acute inpatient stay) within the 14 days immediately preceding admission to home care is associated with the lowest costs during the 60-day episode." Accordingly, CMS designed the Home Health Resource Groups to provide for a lower payment for HHA services rendered to beneficiaries discharged from an acute care hospital within the 14 days immediately preceding admission to home health care.

Overpayments occurred because HHAs had not established the necessary controls to identify all inpatient stays and so prevent the incorrect billing for services. In addition, Palmetto Government Benefits Administrators (Palmetto) did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

We estimate that Palmetto made approximately $10 million in overpayments for 29,249 claims.

RECOMMENDATIONS

We recommend that Palmetto:

- recover the $57,861 in overpayments for the claims in the sample,

- review the balance of the universe to identify and recover additional overpayments (we estimate the total overpayments to be $10,043,328),

- conduct postpayment data analysis, subsequent to the period of the audit, to detect improperly paid HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions as necessary, and

- provide education to HHAs to ensure that beneficiary discharge data is completed accurately on the patient assessment instruments.

In a letter dated August 29, 2003, Palmetto said in response to our draft report that the home health prospective payment system was a new system during the period of review and that education efforts since then may have reduced payment errors. Palmetto indicated it would review individual files before agreeing with the overpayment determination. Details of Palmetto's comments are discussed after the Recommendations section of this report and included in their entirety in Appendix C. On October 24, 2003, subsequent to the issuance of our draft report, CMS published Transmittal 13 (Publication 100-04—Medicare Claims Processing), Change Request 2928, which announced payment safeguards specifically designed to address the "payment vulnerability that [the] OIG . . . identified" in this and companion reports. This transmittal also gives additional instructions to regional home health intermediaries regarding the treatment of claims with a prior hospital stay.

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INTRODUCTION

BACKGROUND

Law

The Balanced Budget Act of 1997, as amended by the Medicare, Medicaid and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000, mandated the CMS to implement a prospective payment system for Medicare HHA services. CMS implemented a prospective payment system for HHAs effective October 1, 2000.

Home Health Resource Groups

The HHA prospective payment system utilizes a classification system that groups home health services into 80 mutually exclusive groups called Home Health Resource Groups. Each Home Health Resource Group forms the basis for a five-character Health Insurance Prospective Payment System code that represents the beneficiary's needs over a 60-day service period, called an episode.

The Outcome and Assessment Information Set, referred to as "OASIS," is a lengthy group of standardized data elements used to assess the needs of each home health patient. The OASIS is, in large part, the basis for determining which Home Health Resource Group a particular claim falls into and, as a result, what payment is ultimately warranted for the services provided. Data elements taken almost entirely from OASIS are organized into three dimensions: clinical severity, functional status, and service utilization. The service utilization dimension includes the patient's use of inpatient services in the 14 days preceding admission to home care. A patient's "scores" within each of these dimensions are totaled, and a Home Health Resource Group assigned.

Palmetto

CMS contracts with four regional home health intermediaries nationwide to assist in administering the home health benefits program. Home health intermediaries process claims and conduct audits of cost reports submitted by HHAs. Palmetto, one of four regional home health intermediaries, processes Medicare claims and conducts audits of cost reports submitted by 3,500 HHAs in 16 States: Alabama, Arkansas, Florida, Georgia, Illinois, Indiana, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Ohio, Oklahoma, South Carolina, Tennessee, and Texas. Claims processed by the other three home health intermediaries are the subject of similar Office of Inspector General (OIG) audits.

Payment for HHA Services

HHAs submit claims for reimbursement using OASIS codes that are designed to match the reimbursement amount to the amount of services required to treat the patient. For example, a K claim represents an HHA claim with low service utilization and an M claim represents an HHA claim with high service utilization. CMS has determined that patients who were inpatients in a hospital within 14 days prior to HHA treatment generally require fewer services and thus, the HHA should code those claims at a lower utilization level. The reduced service utilization level would therefore result in a lower reimbursement to the HHA as shown in the examples that follow.

EXAMPLES OF INCORRECTLY BILLED K AND M CLAIMS

Sample Number	HHA-Billed HIPPS* Code	HHA Service Start Date	Original Payment Amount	Hospital Discharge Date	HIPPS Code Revised per OIG	OIG Revised Payment Amount	Amount Overpaid
K-30	HAG**K**1	7/21/2001	$1,729.30	7/13/2001	HAG**J**1	$1,555.67	$173.63
M-36	HBH**M**1	5/02/2001	$3,859.96	4/22/2001	HBH**L**1	$3,390.43	$469.53

***** Health Insurance Prospective Payment System.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to determine whether HHAs properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals.

Scope

The audit included Palmetto payments for HHA claims with dates of service from October 1, 2000 through September 30, 2001. During this period, there were 29,249 K and M claims that had total payments of $88,387,331 for which there was an inpatient hospital discharge within 14 days prior to the start of the HHA episode—8,391 K claims valued at $15,878,637 and 20,858 M claims valued at $72,508,694. K and M claims were the only categories of HHA claims that would have been affected by erroneous coding of previous hospital stays. Our audit period covered paid claims with HHA dates of service from October 1, 2000 through September 30, 2001.

Methodology

To accomplish the objective, we:

- reviewed applicable Medicare laws and regulations;

- extracted the Palmetto paid claims data from the National Claims History file for FY 2001 and identified claims that HHAs submitted with codes designating no hospital discharge within 14 days prior to the home health admission;

- performed a computer match of these data to the beneficiaries' inpatient hospital data in the National Claims History file in order to obtain a data file of K and M claims with a hospital discharge within 14 days prior to the HHA episode; this computer match identified 29,249 claims totaling $88,387,331;

- selected a stratified random sample of 99 (initially 100, see Appendix A for sampling methodology) K paid claims and 100 M paid claims;

- obtained the common working file data for the sample HHA claims and the corresponding inpatient hospital claims and recalculated the correct payment for the sample claims to determine overpayment amounts;

- contacted representatives of selected HHAs to validate billing errors and determine the underlying cause of noncompliance and any recently developed control procedures to facilitate compliance with Medicare billing requirements (we reviewed the five HHAs in Region IV having at least two claims and the largest dollar volume in our sample);

- contacted one skilled nursing facility and three rehabilitation facilities to determine how these referral providers could facilitate HHA compliance in completing the OASIS; and

- utilized a stratified variable appraisal program to estimate the overpayments to HHAs under the payment jurisdiction of Palmetto (see Appendix B for sample results and projections).

Fieldwork was performed at the OIG field office in Tallahassee, Florida; at Palmetto in Columbia, South Carolina; at selected HHAs; and at the OIG Atlanta Regional office. Fieldwork was conducted from January 2003 through May 2003.

We issued a draft report to Palmetto on July 30, 2003 and received Palmetto's comments on August 29, 2003. Palmetto declined an exit conference after receiving the draft report.

The review of internal controls at Palmetto was limited to obtaining an understanding of its claims processing system edits and procedures to detect improperly billed Medicare HHA claims

and to identify and recover overpayments. In addition, the internal control review of selected HHAs was limited to those controls concerning the creation and submission of Medicare HHA claims.

The audit was conducted in conjunction with other OIG audits of claims processed by each of the four regional home health intermediaries nationwide. The audit was made in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We identified 29,249 HHA claims for which there was an inpatient hospital discharge within 14 days preceding the home health services. From a statistically valid sample of 199 of these claims, we identified overpayments to HHAs totaling $57,861. The claims should have been paid at a lower rate, but were not because the OASIS for these beneficiaries was not completed in accordance with 42 CFR § 484.

Overpayments occurred because HHAs had not established the necessary controls to identify all inpatient stays and so prevent the incorrect billing for services. In addition, Palmetto did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

HHA PROSPECTIVE PAYMENT SYSTEM REGULATIONS

According to 42 CFR § 484.55, HHAs must complete for each HHA patient, a patient-specific comprehensive assessment that accurately reflects the patient's current health status. HHAs use the OASIS to complete the comprehensive patient assessment. Medicare payments to HHAs under the prospective payment system are based on a home health case-mix system that uses selected data elements from the OASIS.

The three areas assessed on the OASIS include the (1) clinical severity of the patient's condition, (2) the patient's ability to carry out activities of daily living such as bathing, and (3) medical services the patient received in the preceding 14 days. When HHAs assess the needs of new home health patients, OASIS requires them to identify all facilities from which the patients have been discharged in the previous 14 days. This response has a direct impact on the amount of Medicare reimbursement. HHAs receive higher payments for providing services that were not preceded by an inpatient hospital discharge within 14 days of the HHA episode.

HHA BILLING ERRORS

HHAs incorrectly billed and Palmetto paid claims for services to beneficiaries who received HHA services. The claims were billed and paid as if the beneficiary had not had an inpatient hospital discharge within 14 days prior to the HHA services when in actuality there was an inpatient hospital discharge within 14 days of receiving the HHA services.

We determined that HHA billing errors existed by extracting the HHA prospective payment system claims data for Palmetto paid claims from the National Claims History file for FY 2001 and identifying claims that HHAs submitted with codes designating no hospital discharge within 14 days prior to the home health admission. We then performed a computer match of these data to the beneficiaries' inpatient hospital data in National Claims History file in order to obtain a data file of K and M claims with a hospital discharge within 14 days prior to the HHA episode.

This computer match identified 29,249 claims totaling $88,387,331. From the computer match, we selected a stratified random sample of 99 (initially 100—see Appendix A for sampling methodology) K paid claims and 100 M paid claims. We obtained the common working file data for the sample HHA claims and the corresponding inpatient hospital claims and, by comparison, verified that the claims history agreed with the match data.

To verify that Palmetto paid the 199 sample claims, we used Palmetto's online HHA prospective payment system claims calculator to recalculate the payment amount. We calculated what the claims payment amounts should have been considering a hospital discharge within 14 days prior to the HHA services. Based on our recalculations, we determined that HHAs were overpaid for each of the 199 claims.

BILLING AND PAYMENT CONTROLS NOT ESTABLISHED

The HHAs incorrectly billed services because they had not established the necessary controls to prevent the incorrect billing of claims for which there was an inpatient hospital discharge within the 14 days prior to the HHA episode. Furthermore, we determined that Palmetto had not established adequate postpayment controls to detect HHA claims that were billed incorrectly and recover the overpayments.

To gain a further understanding of the cause(s) for the billing errors, we contacted the five HHAs in Region IV having at least two claims with the largest dollar volume in our sample. The representatives of each of these 5 HHAs confirmed that the claims (11 of the 199 sample claims) were billed as if the beneficiary had not had an inpatient hospital discharge within 14 days prior to the HHA services when in actuality there was such a discharge preceding the HHA episode. The HHAs did not always accurately complete the OASIS. Of the 5 HHAs that we contacted, all 5 mistakenly identified only the most recent postacute care facility discharge during the 14 days preceding the home health episode and, therefore, did not necessarily capture hospital discharges within the 14-day window.

The five HHAs that we contacted advised that they were not always able to obtain the necessary information to accurately complete the OASIS. Specifically, the information sources available to HHAs—beneficiaries, family members, and recent caregivers—could not always be depended upon for accurate hospital discharge information. Furthermore, the one skilled nursing home and three rehabilitation hospitals that we contacted advised that the inpatient hospital discharge

information needed by HHAs to complete the OASIS was not always included in the referral facility's discharge summary. However, according to these institutions, this information was ultimately available in the discharge summary provided by the hospital to the referral facility.

Palmetto officials told us that overpayments to HHAs were not recovered because Palmetto had not initiated postpayment data analysis to detect HHA claims vulnerable to this billing error.

MEDICARE PROGRAM OVERPAYMENTS

The billing errors for all 199 claims in the stratified random sample resulted in overpayments of $16,357 for the 99 K claims and $41,504 for the 100 M claims, or total payment error of $57,861. Projecting the sample results to the universe of K and M claims with an inpatient hospital discharge within 14 days of the HHA episode, we estimate that Palmetto made $10 million in overpayments to HHAs for services during FY 2001.

RECOMMENDATIONS

We recommend that Palmetto:

- recover the $57,861 in overpayments for the claims in the sample,
- review the balance of the universe to identify and recover additional overpayments (we estimate the total overpayments to be $10,043,328),
- conduct postpayment data analysis, subsequent to the period of the audit, to detect improperly paid HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions as necessary, and
- provide education to HHAs to ensure that beneficiary discharge data are completed accurately on the patient assessment instruments.

PALMETTO COMMENTS AND OIG RESPONSE

Palmetto Comments

In a letter dated August 29, 2003, Palmetto said in response to our draft report that the home health prospective payment system was a new system during the period of review and that education efforts regarding OASIS were underway. In addition, Palmetto noted some of the complexities involved with postpayment safeguards, including identifying hospital stays not paid by Medicare, limitations in claims history files, time lags in the filing period for hospital claims, and limitations on funding for postpayment reviews. Due to these complexities and to ensure adjustments had not already occurred, Palmetto officials believed a review of the files and provider records was required before they could agree with the overpayment determinations.

The complete text of Palmetto's comments is included as Appendix C to this report.

OIG Response

The OIG will provide Palmetto staff with the data file from which the sample was drawn to help in the overpayment recovery effort.

APPENDICES

SAMPLING METHODOLOGY

OBJECTIVE

The objective of the audit was to determine whether HHAs properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals.

POPULATION

The population is HHA claims paid by Palmetto with a date of service during FY 2001 having a K or M in the fourth position of the five-character health insurance prospective payment system code that were preceded by an inpatient hospital discharge within 14 days of the home health episode.

Stratum Number	Type of Claim	Number of Claims	Payment Amount
1	K	8,391	$15,878,637
2	M	20,858	72,508,694
	Total	29,249	$88,387,331

SAMPLE DESIGN

The audit utilizes a stratified random sample consisting of two strata—one for K paid claims and one for M paid claims with dates of service during FY 2001. Error amounts were determined by subtracting the OIG-calculated, correct payment amount from the original reimbursement amount to the provider.

SAMPLE SIZE

The sample initially consisted of 100 claims for each stratum from the identified population. There were a limited number of situations in which items appeared in both strata. After eliminating all duplicates, the sample of K claims was reduced to 99 sample items.

SAMPLE RESULTS AND PROJECTIONS

Sample Results

Stratum Number	Number of Claims	Sample Size	Value of Sample	Number of Errors	Value of Errors
1	8,391	99	$184,977	99	$16,357
2	20,858	100	372,972	100	41,504
Total	29,249	199	$557,949	199	$57,861

Variable Projections

The point estimate of the sample was $10,043,328 with a precision of plus or minus $552,635 at the 90-percent confidence level.

Palmetto GBA
Post Office Box 100134
Columbia, South Caroline 29202-3134

Bruce W. Hughes
Executive Vice President and Chief Operating Officer

August 29, 2003

Mr. Charles J. Curtis
Regional Inspector General for Audit Services, Region IV
Office of Inspector General
HHS/OIG/OAS
61 Forsyth Street, S.W., Room 3T41
Atlanta, Georgia 30303-8909

Report Number: A-04-03-00018

Dear Mr. Curtis:

This is in response to the results of your draft report titled *Review of Controls Over Home Health Payments at Palmetto GBA.*

Based on the report findings and recommendations, Palmetto GBA would like to make the following comments:

- During the audit, claims with dates of service from October 1, 2000 to September 30, 2001 were reviewed. The Home Health PPS payment system, which is a new payment system, was implemented on October 1, 2000. It should be recognized that during this transition period, home health agencies and RHHIs were addressing many implementation concerns. The volatility of the environment should be considered in any judgments about controls in place during this period.

- The study points to a need for education of home health agencies regarding the proper reporting of OASIS item M0175. Education efforts regarding OASIS have been on-going during the past two years, which may impact the extent to which these errors persist. It should also be noted that primary education regarding OASIS is performed by State agencies, not by RHHIs.

- Adjustments to the claims identified in the OIG files cannot be initiated without research of claims history, since provider adjustments to correct the error may have already occurred. It should be recognized that this is a labor-intensive process and would complicate the effort involved.

- It is important to recognize that the institution of post-payment safeguards can never be entirely accurate. No process implemented by Medicare intermediaries can account for hospital stays paid by other payers, but which would also be scored on OASIS.

- The ability to perform subsequent post-payment data analysis is limited by our claims history file. We could only identify hospital stays paid at our site. Lacking direct access to CWF or NCH paid claims history without an individual, manual process, a national process for this analysis at CMS direction would need to be developed.

- In order for post-payment analysis to be complete, there will always be a significant time delay involved. The hospital claim associated with a home health episode has the same 15-27 month timely filing period as any other Medicare claim. This period would need to be fully elapsed before a comprehensive analysis can be done. It is notable that the filing period for the first year of HH PPS was not fully elapsed until December 31, 2002.

- It is also important to note that post-payment review funding is limited, and that pursuing research on these cases can only occur within these limits.

- Because of the reasons noted above, Palmetto GBA believes that careful review of the files and provider records is required before determining if we agree with the overpayment determinations.

We do wish to note that these circumstances are not unique to Palmetto GBA. We have discussed this situation and the findings with CMS and the other RHHIs, who have comments of a similar nature. Because of the factors described in this letter, we feel a coordinated effort among these entities is needed before additional action taken.

Sincerely,

Bruce Hughes