DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
Room 3T41
61 Forsyth Street, S.W.
Atlanta, Georgia 30303-8909

JUL 24 1998

CIN: A-04-98-03009

Ms. Ann Archibald
Vice President of Medicare Administration
Mail Code AH-100
Blue Cross and Blue Shield of South Carolina
I-20 East at Alpine Road
Columbia, South Carolina 29219-0001

Dear Ms. Archibald:

We have enclosed two copies of our report on the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, Assist Audit of HCFA's FY 1997 Financial Statements at Palmetto Government Benefits Administrators (PGBA). Also, we forwarded a copy of this report to the action official named below for his/her review and any action deemed necessary.

The HHS action official will make the final determination as to actions that need to be taken on all matters reported. We request that you respond to the 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 this final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23) OIG, OAS reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to the exemptions in the Act which the Department chooses to exercise (see 456 Code of Federal Regulations Part 5).

To facilitate identification, please refer to Common Identification Number (CIN) A-04-98-03009 in all correspondence related to this letter.

Sincerely yours,

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

Enclosure

Direct Reply to HHS Action Office:

Rose Crum-Johnson, Regional Administrator
Health Care Financing Administration
U.S. Department of Health and Human Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

ASSIST AUDIT OF HCFA'S FY 1997 FINANCIAL STATEMENTS AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS

JUNE GIBBS BROWN
Inspector General

JULY 1998
A-04-98-03009

GLOSSARY OF ACRONYMS

BCBSSC	Blue Cross Blue Shield of South Carolina
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CIN	Common Identification Number
CWF	Common Working File
DMERC	Durable Medical Equipment Regional Carrier
EDP	Electronic Data Processing
FI	Fiscal Intermediary
FY	Fiscal Year
GAO	General Accounting Office
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
HI	Hospital Insurance
IG	Inspector General
MCM	Medicare Carriers Manual
OAS	Office of Audit Services
OIG	Office of Inspector General
OMB	Office of Management and Budget
PGBA	Palmetto Government Benefits Administrators
PRO	Peer Review Organization
SMI	Supplementary Medical Insurance
SNF	Skilled Nursing Facility
VIPS	Viable Information Processing System
VMS	VIPS Medicare System

EXECUTIVE SUMMARY

BACKGROUND

The Health Care Financing Administration (HCFA), an agency of the U.S. Department of Health and Human Services (HHS), has primary responsibility for administering the Medicare program. The agency carries out most Medicare operational activities through contractors that include fiscal intermediaries (FI), carriers, durable medical equipment regional carriers (DMERC), and peer review organizations (PRO). Blue Cross and Blue Shield of South Carolina (BCBSSC), doing business as Palmetto Government Benefits Administrators (PGBA) serves as both the FI and carrier for the State of South Carolina as well as the DMERC and regional home health intermediary (RHHI) for several States.

In Fiscal Year (FY) 1997, almost 39 million beneficiaries were enrolled in the Medicare program nationwide, and HCFA incurred about $207 billion in Medicare benefit payments expenses for health care services.

The Chief Financial Officers (CFO) Act of 1990 requires the head of each executive agency to annually prepare and submit to the U.S. Office of Management and Budget (OMB) financial statements that fully disclose the financial position and results of operations for all trust and revolving funds and, to the extent practical, each office, bureau, and activity of the agency which performed substantial commercial functions during the preceding FY.

The CFO Act also requires the Inspector General (IG), for each agency having an IG, to audit the financial statements in accordance with applicable generally accepted government auditing standards. The IG may select an independent external auditor to conduct the audit.

In addition, the CFO Act also requires each agency to improve its systems of financial management, accounting and internal controls to assure the issuance of reliable financial information.

OBJECTIVES

Our agency's overall audit objective is to express an opinion on HCFA's FY 1997 combined financial statements and to report on their compliance with laws and regulations. An aspect of overall work is to determine whether the Medicare fee-for-service benefit payments expenses are made in accordance with the provisions of Title XVIII and implementing regulations in Title 42 of the U.S. Code of Federal Regulations (42 CFR). Specifically, we were to determine if services were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

The audit procedures for this audit have been designed exclusively for Medicare fee-for-service benefit payments expenses that are claim based. A separate audit approach for non-claim based benefit payments was also developed for use by independent auditors under contract with the OIG. We performed this audit in accordance with generally accepted government auditing standards.

SUMMARY OF FINDINGS

We selected a stratified random sample of 50 beneficiaries for whom PGBA had adjudicated 493 claims during the fourth quarter of FY 1997 - our audit period. The PGBA paid $422,798 for these claims. With the assistance of PGBA and PRO medical review personnel we identified overpayments totaling $29,451 and underpayments totaling $92 for these claims. The overpayments and underpayments occurred for various reasons, including insufficient documentation, incorrect coding of procedures, and lack of medical necessity. We also identified three durable medical equipment (DME) payment errors which may indicate the need for PGBA to improve its claims processing edits. A complete listing of the errors with the reasons for the errors is provided in appendices A and B to this report.

Other independent auditors under contract with the OIG identified reportable conditions with respect to electronic data processing (EDP) controls and non-claims activities and have made recommendations to PGBA in separate reports.

Recommendations

We recommend that PGBA:

- initiate recovery of the overpayments, reimburse the underpayments, and periodically provide us with the status of recovery and reimbursement actions;
- analyze the DME errors noted and make the necessary improvements in their claims processing edits to prevent these or similar types of payment errors from reoccurring; and
- address the recommendations made by the independent auditors and provide us a copy of such responses with respect to EDP controls and non-claims activities.

Comments by PGBA Officials

The PGBA officials concurred with our findings and recommendations and stated they were in the process of analyzing errors noted in the DME claims and will make any improvements in DME processing edits resulting from the analysis. They also have addressed the recommendations made by the independent auditor with respect to EDP controls and non-claims activities (see Appendixes C and D).

INTRODUCTION

The objective of our review at PGBA was to test a sample of claims PGBA adjudicated during the fourth quarter of FY 1997 (July 1, 1997 through September 30, 1997). This quarter was 1 of 12 contractor quarters our headquarters randomly selected nationwide for review. This audit forms a part of our agency's overall audit of HCFA's FY 1997 financial statements.

BACKGROUND

Congress established Medicare under Title XVIII of the Social Security Act by enacting the Social Security Amendments of 1965. Legislated as a complement to Social Security retirement, survivors, and disability benefits, Medicare originally covered people age 65 and over. Since 1972, Congress has broadened the program to cover the disabled, those with end-stage renal disease, and certain others who elect to purchase Medicare coverage.

The HCFA, an agency of HHS, has primary responsibility for administering Medicare. This responsibility includes: formulation of policy and guidelines; contract oversight and operation; maintenance and review of utilization records; and general financing. The HCFA carries out most Medicare operational activities through contractors including FIs, carriers, DMERCs and PROs. In FY 1997, almost 39 million beneficiaries were enrolled in Medicare, and HCFA incurred about $207 billion in Medicare benefit payments expenses for health care services.

Medicare is a combination of two programs - the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) programs. Each program has its own enrollment, coverage, and financing.

HI Program

The HI program, also known as Part A, is generally provided automatically to people age 65 and to most persons who are disabled for 24 months or more who are entitled to either Social Security or Railroad Retirement benefits. Most HI enrollees do not pay any enrollment premium, but some who are otherwise unqualified for Medicare may purchase HI coverage if they also elect to purchase SMI coverage.

The HI program pays participating hospitals, skilled nursing facilities (SNF), home health agencies, and hospice providers for covered services rendered to Medicare Part A enrollees. The FIs process and pay both Part A and outpatient Part B claims.

The HI program is financed primarily through contributions from taxable earnings into the HI trust fund. Employees and employers each currently contribute through a mandatory payroll deduction of 1.45 percent of taxable earnings. Self-employed individuals currently contribute 2.90 percent of their taxable earnings.

SMI Program

The SMI program, also known as Part B, is optional and available to: almost all resident citizens age 65 and over; certain aliens age 65 and over -- even those not entitled to Part A based on eligibility for Social Security or Railroad Retirement benefits; and disabled beneficiaries entitled to Part A benefits. Almost all HI enrollees enroll in the SMI program.

The SMI program covers physician services as well as certain non-physician services including: clinical laboratory tests; durable medical equipment (prosthetics and orthotics); flu vaccinations; drugs which cannot be self-administered (except certain anticancer drugs); most supplies; diagnostic tests; ambulance services; some therapy services; and certain other services Part A does not cover.

The SMI program is financed through monthly beneficiary premium payments (usually deducted from Social Security benefits) along with significant contributions from general revenues of the Federal Government. Carriers process and pay Part B claims.

Benefit Payments

For both Parts A and B, beneficiaries are responsible for charges not covered by the Medicare program as well as any applicable deductibles and coinsurance. For example, Medicare usually pays 80 percent of Part B services. The beneficiary is responsible for the remaining 20 percent as well as an annual deductible.

In FY 1997, PGBA, as both FI and carrier (including DMERC), reported $10.347 billion in total funds expended on the HCFA Form 1522s for Medicare Part A and Part B. Of that amount, PGBA reported $3.113 billion during the fourth quarter. The HCFA utilizes total funds expended amounts from the HCFA Form 1522s to calculate the Medicare benefit payments expenses reported in their financial statements.

Legislative and Other Requirements

The CFO Act of 1990 requires the head of each executive agency to annually prepare and submit to the U.S. OMB financial statements that fully disclose the financial position and results of operations for all trust and revolving funds, and to the extent practical, each office, bureau, and activity of the agency which performed substantial commercial functions during the preceding FY.

The CFO Act also requires the IG, for each agency having an IG, to audit the financial statements in accordance with applicable generally accepted government auditing standards. The IG may select an independent external auditor to conduct the audit.

In addition, the CFO Act requires each agency to improve its systems of financial management, accounting and internal controls to assure the issuance of reliable financial information.

OBJECTIVES

Our agency's overall audit objective is to express an opinion on HCFA's FY 1997 combined financial statements and to report on their compliance with laws and regulations. One aspect of our overall work is to determine whether the Medicare fee-for-service benefit payments expenses are made in accordance with the provisions of Title XVIII and implementing regulations in Title 42 CFR. Specifically, we were to perform substantive tests on claims PGBA adjudicated during the fourth quarter of FY 1997 (July 1 through September 30, 1997) for a sample of 50 beneficiaries.

Our testing was to determine if services were: (1) furnished by certified Medicare providers to eligible beneficiaries; (2) reimbursed by Medicare contractors in accordance with Medicare laws and regulations; and (3) medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

We conducted our audit in accordance with Government Auditing Standards issued by the Comptroller General of the United States, financial statement audit methodologies prescribed by the General Accounting Office (GAO), and OMB Bulletin 93-06, "Audit Requirements of Federal Financial Statements." These standards require that we plan and perform our audit to obtain reasonable assurance that HCFA's financial statements are free of material misstatement and that HCFA, as well as Medicare contractors such as PGBA, have complied with applicable laws and regulations.

SCOPE AND METHODOLOGY

We performed our review from August 1997 to May 1998 at the PGBA offices in Columbia, South Carolina and the OIG offices in: Birmingham, Alabama; Atlanta, Georgia; Boston, Massachusetts; and Baltimore, Maryland. We provided PGBA a draft report for comments on May 29, 1998. The relevant PGBA comments are summarized after each finding and the comments are appended in their entirety to this report (see Appendix C).

In addition to our work, Clifton Gunderson, LLC contracted with HHS, OIG to review two areas related to our audit: (1) a review of the EDP general controls without program change and application controls of VMS [VIPS (Viable Information Processing System) Medicare System],

and (2) certain financial amounts not related to claims. Clifton Gunderson reported the results of these reviews separately to PGBA.

We relied on our substantive tests of PGBA's adjudicated claims to determine the propriety of Medicare benefit payments expenses PGBA reported to HCFA. To perform our substantive tests, OIG headquarters first randomly selected 12 contractor FY quarters (primary sampling unit) for review. The fourth quarter of FY 1997 (July 1 through September 30, 1997) for PGBA was one of the quarters selected.

Our substantive testing universe consisted of $3,229,072,847 PGBA paid during the fourth quarter of FY 1997 for 9,617,323 claims for services provided to 2,112,416 beneficiaries. For the same period, PGBA reported a lessor amount ($3,112,783,317) as net expenses on the HCFA Form 1522s. Net expenses reflect claims paid plus or minus costs associated with non-claims activities. In this instance, net expenses were $116,289,430 less than the amount paid for claims; that is non-claims activities (cost report settlements, overpayment collections, periodic interim payments, etc.) served to reduce total expenses. These amounts were audited by other independent auditors under contract with OIG.

We selected a stratified random sample of 50 beneficiaries (secondary sampling unit) from claim files PGBA provided containing all claims PGBA adjudicated during our audit period. Prior to selecting the sample of beneficiaries, we reconciled these files to: (1) PGBA's FI and carrier check registers; and (2) Medicare benefit expenses PGBA reported on the HCFA 1522s for the fourth quarter of FY 1997.

The PGBA adjudicated 493 claims for the 50 beneficiaries. The 493 claims consisted of 184 FI claims and 309 carrier claims (including DMERC) for which PGBA paid a total of $422,798 ($373,710 for FI claims and $49,088 for carrier claims).

After we identified the claims for the beneficiaries in the sample, we determined that the claims were: (1) for covered services furnished by eligible providers to eligible beneficiaries; (2) were reimbursed by PGBA in accordance with Medicare laws and regulations, and (3) were medically necessary, recorded and documented in beneficiary medical records. To accomplish these objectives, we performed audit steps to verify:

- the providers and beneficiaries were Medicare eligible;
- the PGBA paid the correct amount to the providers and beneficiaries;
- any coinsurance and deductible amounts were correct;
- Medicare was the correct primary/secondary payer;
- the PGBA paid only once for a service (eliminating duplicate claims); and

- the PGBA included all payments in the monthly HCFA Form 1522 amount for "Total Funds Expended This Month" for each month in the quarter.

We obtained assistance from the medical review staffs of PGBA and Carolina Medical Review, (the South Carolina PRO) to review the selected claims. The medical review personnel for these organizations determined if the paid claims were for services actually provided, correctly coded, medically necessary, and supported by medical records.

We used the following Medicare claim categories to report our substantive testing results:

- Hospital Inpatient - Prospective Payment System
- Hospital Inpatient - Non-Prospective Payment System
- SNF Inpatient
- Home Health
- Hospital and SNF Outpatient
- Ambulatory Surgery
- Part B Services Paid by Carriers such as:
  - Physician Services
  - Clinical Laboratories
  - Ambulance Services
- Durable Medical Equipment

For the claim types listed above we performed tests to ensure compliance with the Medicare laws and regulations.

FINDINGS AND RECOMMENDATIONS

We identified overpayments of $29,451 and underpayments of $92 in the sample of $422,798 of Medicare benefit payments. We also identified three DME payment errors which may warrant PGBA improving its claims processing edits. Other independent auditors under contract with OIG identified controls that needed improvement relative to EDP and non-claim transactions.

SUBSTANTIVE TESTING RESULTS

With the assistance of PGBA and the South Carolina PRO, we identified overpayments totaling $29,451 and underpayments totaling $92, a net overpayment of $29,359 ($18,810 in FI payments and $10,549 in carrier payments). See Appendix A for a listing of the dollar amounts of errors and number of errors by claim type. See Appendix B for a list of all the errors by claims and item of service within each claim along with the reason for each error.

We relied on the following criteria to identify errors.

Federal regulations require that Medicare providers maintain medical records that contain sufficient evidence to support, as applicable, admission, services furnished, diagnoses, treatment performed and continued care for claims billed.

The Social Security Act § 1862 states that no payment under Medicare Part A and Part B can be made for items and services which: (1) are not reasonable or necessary; or (2) do not contribute meaningfully to the treatment of an illness or injury or the functioning of a malformed body member (i.e., personal comfort items).

The Medicare Carriers Manual (MCM), Part 3, §5114 states that if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the battery that includes the tests, the carrier should make payment at the lesser amount for the battery of tests.

The MCM Part 3, §4824, states that because the Medicare fee schedule amount for surgical procedures includes all services that are part of a global surgery package, carriers should not pay more than the fee schedule amount when a bill is fragmented (unbundled).

Intermediary Letter 372 addresses the billing of professional services by a physician in a teaching setting when residents are involved. In essence, the physician billing for the services must have either performed the service or have been present and supervised the resident when the service was performed.

The MCM Part 3, §5246.4, specifies that when a carrier determines that a less expensive level of service would have met the patient's medical needs or was actually furnished, the carrier must reimburse the provider for the less expensive level of service.

DMERC Claims Processing Edits

Like other Medicare contractors, PGBA utilizes electronic edits within their claims processing systems to identify potentially erroneous claims (e.g., duplicates, erroneous billings). During our verification of the amounts PGBA paid for DME claims, we identified three payment errors which may warrant PGBA improving its claims processing edits.

- The PGBA improperly paid $100.35 for a front wheel caster (a manual wheelchair accessory) when the beneficiary had a power wheelchair. The supplier billed for the purchase of the front wheel caster on the same claim as the purchase of the power wheelchair.

- The PGBA improperly paid $35.00 for two left thumb attachments for a wrist and hand brace, but Medicare allows only one attachment per side.

- The PGBA improperly paid $19.90 for a free-standing trapeze bar for a beneficiary confined to a hospital bed. Medicare regulations do not allow for this type of trapeze bar unless the patient is somewhat ambulatory. The PGBA previously paid for the rental of the hospital bed for the beneficiary.

Recommendations

We recommend that PGBA:

- o initiate recovery of the overpayments, reimburse the underpayments, and periodically provide us with the status of recovery and reimbursement actions; and

- o analyze the DME errors noted and make the necessary improvements in their claims processing edits to identify and prevent these or similar types of payment errors from reoccurring.

Comments by PGBA Officials

In their written response to our draft report, PGBA officials stated they:

- concurred that the claims identified in our draft report resulted in incorrect overpayments and underpayments, agreed with the calculated amounts, were taking action to recoup the overpayments and reimburse the underpayments, and would provide periodic status updates on their recovery and reimbursement actions;

- are analyzing errors noted in the DME claims and will make any improvements in the DME processing edits as a result of the analysis; and

- noted that, while not included as a recommendation in our draft report, they will also implement beneficiary-specific medical review edits to prospectively review any additional HI claims submitted for the beneficiaries with denials that were identified in our draft report.

RESULTS OF WORK PERFORMED BY OTHERS

Clifton Gunderson LLC contracted with OIG to review two areas related to our audit: (1) a review of the EDP general controls without program change and applications controls of VMS, and (2) certain financial amounts not related to claims. The results of these reviews have been reported separately to PGBA by Clifton Gunderson. In these reports Clifton Gunderson made recommendations to correct noted conditions.

Recommendation

We recommend that PGBA address the recommendations made by Clifton Gunderson in their reports and provide us with a copy of their responses.

Comments by PGBA Officials

The PGBA officials also stated in their written comments that they have addressed the recommendations the independent auditors made with respect to EDP controls and non-claims activities and attached a copy of the independent auditors' response and resulting correspondence from them.

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
DOLLAR AMOUNT OF ERRORS BY TYPE OF CLAIM

The listing below shows the net dollar amount of errors by type of claim. We calculated the percent of errors by dividing the Dollar Errors Identified by the Dollars Reviewed for each type of claim. For example, for Hospital Inpatient-PPS, dividing **$1,542.27 by $152,237.05 resulted in a 1.01% error rate. These percentages are for informational purposes only regarding the** claims in the sample. They cannot be used to derive any conclusions regarding Palmetto Government Benefits Administrators' paid claims universe by type of claim.

TYPE OF CLAIM	DOLLARS REVIEWED	DOLLAR ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	$152,237.05	$1,542.27	1.01%
Hospital Inpatient-Non-PPS	$49,928.72	$ -0-	0.00%
SNF Inpatient	$24,629.31	$ -0-	0.00%
Home Health Agency	$144,434.31	$16,874.22	11.68%
Hospital, SNF Outpatient	$1,757.32	$393.82	22.41%
Ambulatory Surgery	$723.93	$ -0-	0.00%
SUBTOTAL	$373,710.64	$18,810.31	5.03%
Part B	$20,001.03	$616.60	3.08%
DMERC	$29,086.54	$9,932.25	34.15%
TOTAL	$422,798.21	$29,359.16	6.94%

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
NUMBER OF CLAIMS WITH ERRORS BY TYPE OF CLAIM

The listing below shows the number of claims with errors by type of claim. We calculated the percent of errors by dividing the Claim Errors Identified by the Claims Reviewed for each type of claim. For example, for Hospital Inpatient - PPS, dividing 2 by 14 resulted in a 14.29% error rate. **These percentages are for informational purposes only regarding the claims in the sample.** They cannot be used to derive any conclusions regarding Palmetto Government Benefits Administrators' paid claims universe by type of claim.

TYPE OF CLAIM	CLAIMS REVIEWED	CLAIM ERRORS IDENTIFIED	PERCENT OF ERRORS
Hospital Inpatient-PPS	14	2	14.29%
Hospital Inpatient-Non-PPS	6	0	0.00%
SNF Inpatient	11	3	27.27%
Home Health Agency	137	62	45.26%
Hospital, SNF Outpatient	13	1	7.69%
Ambulatory Surgery	3	0	0.00%
SUBTOTAL	184	68	36.96%
Part B	164	25	15.24%
DMERC	145	16	11.03%
TOTAL	493	109	22.11%

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	19716701319005	302.54	7.00	26	Medically Unnecessary
2	19716800666605	91.00	16.00	25	Medically Unnecessary
3	19716900710705	62.30	1.00	25	Medically Unnecessary
3	19716900710705	96.74	1.00	25	Medically Unnecessary
4	19717000889205	216.63	3.00	25	Medically Unnecessary
5	19717001123305	112.00	2.00	25	Medically Unnecessary
5	19717001123305	84.00	3.00	25	Medically Unnecessary
6	19717100147705	65.45	1.00	26	Medically Unnecessary
7	19717101320605	302.54	7.00	26	Medically Unnecessary
8	19717500981505	4.94	1.00	35	Non-covered Service
9	19717601420705	104.11	1.00	21	Insufficient Documentation
10	19717700568805	216.63	3.00	25	Medically Unnecessary
11	19718100820705	345.76	8.00	26	Medically Unnecessary
12	19718301350005	56.00	1.00	25	Medically Unnecessary
12	19718301350005	84.00	3.00	25	Medically Unnecessary
13	19718302224005	169.26	2.00	21	Insufficient Documentation
14	19718401250005	18.44	1.00	25	Medically Unnecessary
14	19718401250005	216.63	3.00	25	Medically Unnecessary
14	19718401250005	115.00	5.00	25	Medically Unnecessary
15	19718800887505	72.21	1.00	25	Medically Unnecessary
15	19718800887505	23.00	1.00	25	Medically Unnecessary
16	19718801384605	85.68	1.00	26	Medically Unnecessary
16	19718801384605	518.64	12.00	26	Medically Unnecessary
17	19718902517905		1.00	26	Medically Unnecessary
17	19718902517905	60.00	1.00	26	Medically Unnecessary
18	19719001240605	104.11	1.00	21	Insufficient Documentation
19	19719003161405	393.82	1.00	26	Medically Unnecessary
20	19719101393605	84.00	3.00	25	Medically Unnecessary
21	19719201773905	15.34	1.00	25	Medically Unnecessary
21	19719201773905	144.42	2.00	25	Medically Unnecessary
21	19719201773905	92.00	4.00	25	Medically Unnecessary
22	19719202940005	37.00	1.00	26	Medically Unnecessary
23	19719501216505	216.10	5.00	26	Medically Unnecessary
24	19719503088005	65.37	1.00	26	Medically Unnecessary
25	19719601695005	139.63	1.00	26	Medically Unnecessary
26	19719800946805	96.63	1.00	25	Medically Unnecessary
26	19719800946805	56.94	2.00	25	Medically Unnecessary
27	19719800946905	46.00	2.00	25	Medically Unnecessary
28	19719801231905	56.00	1.00	25	Medically Unnecessary

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
35	19721100802805	115.00	5.00	25	Medically Unnecessary
36	19721200935405	56.00	1.00	25	Medically Unnecessary
36	19721200935405	84.00	3.00	25	Medically Unnecessary
37	19721200980805	104.11	1.00	21	Insufficient Documentation
37	19721200980805	27.30	1.00	26	Medically Unnecessary
38	19721600559305	71.80	1.00	26	Medically Unnecessary
39	19721904611405	22.50	1.00	25	Medically Unnecessary
39	19721904611405	216.63	3.00	25	Medically Unnecessary
39	19721904611405	115.00	5.00	25	Medically Unnecessary
40	19721904945305	84.00	3.00	25	Medically Unnecessary
41	19721906128205	60.00	1.00	25	Medically Unnecessary
41	19721906128205		1.00	26	Medically Unnecessary
42	19722000091105	609.36	8.00	26	Medically Unnecessary
43	19722000944705	20.24	1.00	25	Medically Unnecessary
43	19722000944705	72.21	1.00	25	Medically Unnecessary
43	19722000944705	23.00	1.00	25	Medically Unnecessary
44	19722001327805	136.84	1.00	26	Medically Unnecessary
44	19722001327805	428.40	5.00	26	Medically Unnecessary
45	19722002121605	62.00	1.00	26	Medically Unnecessary
45	19722002121605	186.00	3.00	26	Medically Unnecessary
45	19722002121605	62.00	1.00	26	Medically Unnecessary
46	19722301418205	27.30	1.00	26	Medically Unnecessary
47	19722301472905	112.00	4.00	25	Medically Unnecessary
48	19722403509105	105.00	1.00	21	Insufficient Documentation
48	19722403509105	196.11	3.00	26	Medically Unnecessary
49	19722600730005	22.50	1.00	25	Medically Unnecessary
49	19722600730005	216.63	3.00	25	Medically Unnecessary
49	19722600730005	92.00	4.00	25	Medically Unnecessary
50	19722601122505	56.00	1.00	25	Medically Unnecessary
50	19722601122505	84.00	3.00	25	Medically Unnecessary
51	19722601829605	88.65	1.00	26	Medically Unnecessary
51	19722601829605	670.80	15.00	26	Medically Unnecessary
52	19722701862505	171.36	2.00	26	Medically Unnecessary
53	19723102905005		1.00	21	Insufficient Documentation
54	19723202972808		1.00	21	Insufficient Documentation
54	19723202972808	0.00	1.00	35	Non-covered Service
55	19723300979705	22.50	1.00	25	Medically Unnecessary
55	19723300979705	216.63	3.00	25	Medically Unnecessary
55	19723300979705	92.00	4.00	25	Medically Unnecessary

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

FISCAL INTERMEDIARY CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
56	19723301508605	84.00	3.00	25	Medically Unnecessary
61	19724800691605	290.00	4.00	25	Medically Unnecessary
62	19724801197805	28.27	1.00	25	Medically Unnecessary
62	19724801197805	289.89	3.00	25	Medically Unnecessary
62	19724801197805	56.94	2.00	25	Medically Unnecessary
63	19724801482005	84.00	3.00	25	Medically Unnecessary
64	19725102174805	682.00	11.00	26	Medically Unnecessary
64	19725102174805	558.00	9.00	26	Medically Unnecessary
64	19725102174805	372.00	6.00	26	Medically Unnecessary
64	19725102174805	868.00	14.00	26	Medically Unnecessary
64	19725102174805	124.00	2.00	26	Medically Unnecessary
64	19725102174805	620.00	10.00	26	Medically Unnecessary
65	19725401237405	28.27	1.00	25	Medically Unnecessary
65	19725401237405	289.89	3.00	25	Medically Unnecessary
65	19725401237405	113.88	4.00	25	Medically Unnecessary
66	19725401605605	56.00	1.00	25	Medically Unnecessary
66	19725401605605	84.00	3.00	25	Medically Unnecessary
67	19725601938805	88.65	1.00	26	Medically Unnecessary
67	19725601938805	536.64	12.00	26	Medically Unnecessary
68	19725801752005	103.37	1.00	26	Medically Unnecessary
Total		15,058.53	304.00		

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

CARRIER CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	97171871118000	12.55	1.00	31	Incorrectly Coded
2	97171883350000	11.98	1.00	31	Incorrectly Coded
3	97174877202000	41.62	1.00	21	Insufficient Documentation
4	97175884506000	23.96	2.00	31	Incorrectly Coded
4	97175884506000	11.98	1.00	31	Incorrectly Coded
5	97175884513000	11.98	1.00	31	Incorrectly Coded
6	97177883557000	39.41	1.00	21	Insufficient Documentation
7	97178875142000	11.98	1.00	31	Incorrectly Coded
7	97178875142000	11.98	1.00	31	Incorrectly Coded
8	97181871677000	38.00	1.00	21	Insufficient Documentation
9	97182873307000	11.98	1.00	31	Incorrectly Coded
9	97182873307000	11.98	1.00	31	Incorrectly Coded
10	97182873322000	11.98	1.00	31	Incorrectly Coded
10	97182873322000	23.96	2.00	31	Incorrectly Coded
11	97183870911000	78.06	1.00	40	Service Provided by Other Provider
12	97183870921000	26.63	1.00	31	Incorrectly Coded
13	97183879041000	11.98	1.00	31	Incorrectly Coded
14	97189886537000	47.92	4.00	31	Incorrectly Coded
15	97189886539000	11.98	1.00	31	Incorrectly Coded
16	97191884455000	18.77	1.00	31	Incorrectly Coded
17	97195905090000	6.41	1.00	21	Insufficient Documentation
17	97195905090000	7.86	1.00	21	Insufficient Documentation
18	97199874528000	8.00	1.00	60	Unbundling
19	97213875567000	-6.55	1.00	31	Incorrectly Coded
20	97217870672000	12.55	1.00	31	Incorrectly Coded
21	97220872049000	11.97	1.00	31	Incorrectly Coded
22	97221870034000	24.13	3.70	31	Incorrectly Coded
23	97232113932000	30.43	1.00	21	Insufficient Documentation
24	97234881769000	18.94	1.00	26	Medically Unnecessary
25	97258881087000	32.18	1.00	21	Insufficient Documentation
Total		616.60	37.70		

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

DMERC CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
1	97219750409000	4,019.92	1.00	15	Under OI Investigation
1	97219750409000	0.00	2.00	15	Under OI Investigation
1	97219750409000	42.64	1.00	15	Under OI Investigation
1	97219750409000	31.62	1.00	15	Under OI Investigation
1	97219750409000	171.31	2.00	15	Under OI Investigation
1	97219750409000	43.06	2.00	15	Under OI Investigation
1	97219750409000	164.78	2.00	15	Under OI Investigation
1	97219750409000	231.80	2.00	15	Under OI Investigation
2	97219750410000	252.10	1.00	15	Under OI Investigation
3	97219750411000	199.72	1.00	15	Under OI Investigation
3	97219750411000	756.28	1.00	15	Under OI Investigation
3	97219750411000	128.25	1.00	15	Under OI Investigation
3	97219750411000	108.78	1.00	15	Under OI Investigation
3	97219750411000	110.44	1.00	15	Under OI Investigation
4	97171842111000	66.62	1.00	16	Entity No Longer in Business
4	97171842111000	397.79	1.00	16	Entity No Longer in Business
4	97171842111000	2.40	60.00	16	Entity No Longer in Business
4	97171842111000	133.06	24.00	16	Entity No Longer in Business
4	97171842111000	74.35	6.00	16	Entity No Longer in Business
4	97171842111000	73.98	32.00	16	Entity No Longer in Business
5	97216845705000	66.62	1.00	16	Entity No Longer in Business
5	97216845705000	397.79	1.00	16	Entity No Longer in Business
5	97216845705000	2.40	60.00	16	Entity No Longer in Business
5	97216845705000	133.06	24.00	16	Entity No Longer in Business
5	97216845705000	74.35	6.00	16	Entity No Longer in Business
5	97216845705000	73.98	32.00	16	Entity No Longer in Business
6	97216845706000	66.62	1.00	16	Entity No Longer in Business
6	97216845706000	397.79	1.00	16	Entity No Longer in Business
6	97216845706000	2.40	60.00	16	Entity No Longer in Business
6	97216845706000	133.06	24.00	16	Entity No Longer in Business
6	97216845706000	74.35	6.00	16	Entity No Longer in Business
6	97216845706000	73.98	32.00	16	Entity No Longer in Business
7	97255841968000	66.62	1.00	16	Entity No Longer in Business
7	97255841968000	397.79	1.00	16	Entity No Longer in Business
7	97255841968000	2.40	60.00	16	Entity No Longer in Business
7	97255841968000	133.06	24.00	16	Entity No Longer in Business
7	97255841968000	74.35	6.00	16	Entity No Longer in Business

AUDIT OF HCFA'S FINANCIAL STATEMENTS
FOR FISCAL YEAR 1997
AT PALMETTO GOVERNMENT BENEFITS ADMINISTRATORS
COLUMBIA, SOUTH CAROLINA

DMERC CLAIMS (BY LINE ITEM) WITH IDENTIFIED ERRORS

NO. OF CLAIMS	ICN	AMOUNT QUESTIONED	NO. OF SERVICES QUESTIONED	ERROR CODE	ERROR DESCRIPTION
7	97255841968000	73.98	32.00	16	Entity No Longer in Business
8	97170839085000	63.38	2.00	21	Insufficient Documentation
8	97170839085000	9.72	1.00	21	Insufficient Documentation
9	97230851326000	63.38	2.00	21	Insufficient Documentation
10	97170812389000	-85.44	30.00	26	Medically Unnecessary
11	97192160005000	0.11	1.00	26	Medically Unnecessary
11	97192160005000	9.03	1.00	26	Medically Unnecessary
12	97246817152000	411.97	1.00	31	Incorrectly Coded
13	97195829897000	19.90	1.00	35	Non-covered Service
14	97213834300000	19.45	1.00	35	Non-covered Service
15	97219750409000	100.35	2.00	35	Non-covered Service
16	97219750411000	35.00	1.00	35	Non-covered Service
17	97226826092000	19.90	1.00	35	Non-covered Service
18	97226826093000	12.00	1.00	35	Non-covered Service
Total		9,932.25	560.00		

Medicare

Palmetto Government Benefits Administrators

Post Office Box 100190
Columbia, South Carolina 29202-3190

June 25, 1998

Charles J. Curtis, Regional Inspector General for Audit Services
US DHHS Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW Room 3T41
Atlanta, Georgia 30303-8909

Re: Response to Draft Report (*Assist Audit of HCFA's FY 1997 Financial Statements at Palmetto Government Benefits Administrators*)
CIN: A-04-98-03009

Dear Mr. Curtis:

Palmetto Government Benefits Administrators (PGBA) has reviewed your letter dated May 29, 1998 and the above referenced draft report which accompanied it. With respect to the findings and recommendations of this draft report:

- PGBA concurs with the finding that the claims identified in the draft report resulted in incorrect reimbursements, and also agrees with the calculated amounts. Action is now being taken to correct these reimbursements (recouping the identified overpayments and reimbursing the identified underpayments).

- PGBA is analyzing the errors noted in the durable medical equipment (DME) claims. PGBA will make any improvements in the DME claims processing edits indicated as a result of this analysis.

  In addition, while not included as a recommendation in the draft report, PGBA will also implement beneficiary-specific medical review edits to prospectively review any additional Hospital Insurance (HI) claims submitted for the beneficiaries with denials identified in the draft report.

- PGBA has addressed the recommendations made by the independent auditors (Clifton Gunderson, L.L.C.) with respect to EDP controls and non-claims activities. A copy of the PGBA response and resulting correspondence from the independent auditors is enclosed.

PGBA will provide periodic status updates concerning the status of the recovery and reimbursement actions. If there are any questions, or if I may be of further assistance, please call me at (803)788-0222, ext. 38143.

Sincerely,

E. Ray Bair, CFE
Director, Government Programs Compliance

1 Enclosure

cc: Carol Nicholson, HCFA CO
William R. Horton, PGBA
Ann Archibald, PGBA
Lisa Killian, PGBA
Susan McGuirt, PGBA
Sue Pearcy, PGBA
Roz Catoe, PGBA
Robin Spires, PGBA
Don Wells, PGBA
Bill Crews, PGBA
Barbara Excell, PGBA
Leon Myers, PGBA
John Dart, PGBA

Clifton Gunderson L.L.C.
Certified Public Accountants & Consultants

Golden Triangle I
7833 Walker Drive, Suite 440
Greenbelt, Maryland 20770
(301) 345-0500
(301) 345-0054 Fax
www.cliftoncpa.com

March 30, 1998

Mr. Bruce W. Hughes, Jr., Vice President
Medicare Operations
Palmetto Government Benefits Administrators
P.O. Box 100190
Columbia, SC 29202-3190

Re: HCFA Fiscal Year 1997 Financial Statements Audit

Dear Mr. Hughes:

Thank you for your additional response to our findings. We have incorporated your written response dated March 5, 1998 and have modified some of your initial responses included in the final finding sheets forwarded to you on February 25, 1998.

Please do not hesitate to call me or Mia Leswing at 301-345-0500 if you have any questions.

Sincerely yours,

CLIFTON GUNDERSON L.L.C.

William H. Oliver, CPA
Member

cc: Mr. William R. Horton
Group Vice President, Government Programs
Blue Cross Blue Shield of South Carolina
Columbia, SC 29219

Ms. Ann Archibald
Assistant Vice President
Government Contract Compliance
Blue Cross Blue Shield of South Carolina
Columbia, SC 29219

Ms. Susan McGuirt
Audit Liaison
Blue Cross and Blue Shield of South Carolina
Columbia, SC 29219

Mr. Bruce Randle
Office of Inspector General
N2-25-10, North Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Maria Montilla
Office of Inspector General
N2-25-26, North Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Mr. Ballard Hillman, Audit Manager
OIG Office of Audit Services
101 Marietta Tower, Suite 1401
Atlanta, GA 30301

Ms. Carol Nicholson
Health Care Financing Administration
C3-09-27, Central Building
7500 Security Boulevard
Baltimore, MD 21244-1850

Ms. Rose Crum-Johnson
Consortium Administrator
Health Care Financing Administration
Atlanta Regional Office
101 Marietta Tower, Suite 701
Atlanta, GA 30323-2711

HCFA
FY 97 Financial Statement Audit
Contractor Visit - FI & Carrier
Palmetto Government Benefits Administrators (Palmetto)

Non-Claims Disbursements
September 30, 1997

Finding 1

Subject:	Review of Interim Calculations
Condition:	During the review of the 30 sampled Non-Claims Disbursements and Withholding amounts, four of the items reviewed were tentative settlement calculations and seven were PIP Calculations. Each was examined for Supervisory review. None of the tentative settlements and only one of the PIP calculations were documented as having been reviewed by a Supervisor prior to inclusion in the shared system.
Cause:	The Contractor's policy is to not perform a Supervisory review for all PIP calculations or tentative settlements. Only those performed by inexperienced personnel are routinely reviewed by Senior or Supervisory staff. The Contractor relies upon other procedures to ensure the reviews are accurate and reliable. These include performing internal sample reviews on a annual basis and transaction letter reviews (for completeness and accuracy). The Contractor has indicated it believes review of these areas is not necessary for every calculation as these are interim reviews and every final settlement is reviewed.
Criteria:	Supervisory review should be performed on all PIP Calculations and Tentative Settlements to ensure accuracy and adequacy.
Effect:	By not performing these reviews there is an increased likelihood the individual providers' interim payments will be misstated due to errors generated during the calculation.
Contractor Response:	A review is performed for all interim, PIP and tentative settlement calculations completed by inexperienced personnel. This review is performed by a senior level accountant. Interim, PIP and tentative settlement calculations completed by experienced personnel are not routinely reviewed. As an alternate control technique, Palmetto GBA reviews a random sample of rate reviews and tentative settlements on an annual basis, and reviews on an exception basis on all payments to providers exceeding established tolerance thresholds. Additionally, the accuracy of interim payments is monitored on an ongoing basis, and serves as a key element of each employee's performance review. Palmetto GBA does not believe the benefits of performing a supervisory review on each interim rate, PIP, or tentative calculation justifies the additional cost involved especially given the significant reductions in funding for the Reimbursement function in recent years. Rate reviews and tentatives are by definition estimates, and all interim and tentative settlements are incorporated into the final review when it is finally settled. This is unlike claims coverage determinations, which are subject to post payment review on only a limited basis.

Contractor Response:	In total, interim payments to home health providers equaled 99.45 percent of total payments at final settlement in FY' 97 and 99.40 percent in FY'96. The accuracy levels achieved without a routine supervisory review is well within HCFA's accuracy parameters and is comparable to the previous Aetna Florida contractors, whose operations we assumed. Although the previous Aetna contractor required supervisory review and sign off on rate reviews and tentatives, the results achieved were no better. Nevertheless, if HCFA insists on routine supervisory review, we will proceed with a supplemental budget request for funding to hire the additional resources necessary to perform 100 percent supervisory review of interim payments. Alternatively, we are open to discussions regarding the reprioritization of Reimbursement activities to allocate resources to the supervisory review.

HCFA
FY 97 Financial Statements Audit
Contractor Visit - Fiscal Intermediary and Carrier
Palmetto Government Benefits Administrators (Palmetto)

Provider Audit and Reimbursements
September 30, 1997

Finding 2

Subject:	Incorrect Tracking on the System Tracking for Audit and Reimbursement (STAR) Report
Condition:	The information per the STAR and the information per the Cost Reports do not always appear to be identical. Three variances in the post mark date and one variance in the receipt date were noted in a sample of 10 items.
Cause:	See Contractor's response below.
Criteria:	To ensure the information reported to HCFA is timely and accurate the STAR report should be reconciled to the related Cost Reports being tracked.
Effect:	Without a reconciliation Palmetto does not have assurance that the STAR (and thus the information being reported to HCFA) is timely and accurate.
Contractor Response:	In all three cost reports noted with variances in STAR, the receipt date agreed with the "Completed Date" stamped on the cost report by BCBS of New Mexico. The post mark date was vacant in all cases. Presumably "Completed Date" is what BCBS of New Mexico referred to as the date the cost report was received. The cost reports in question were filed in Fiscal Years 1994 and 1995 to BCBS of New Mexico and settled during Fiscal Year 1997 by Palmetto. Any impact of an erroneous cost report receipt date would have been reflected on the Contractor's reported timely completion of tentative settlements, which would have been reported by BCBS of New Mexico in a prior fiscal year. Effective in October 1995, Palmetto GBA began reporting receipt date and postmark date on the STAR. Palmetto GBA verifies cost report receipt date through the tentative settlement proces. The cost report receipt date is reported to HCFA on the CPE tentative settlement report produced by STAR. This report is reconciled to an EXCEL spreadsheet utilized for tracking as-filed cost reports. Any discrepancies are corrected prior to submitting the report to HCFA.

HCFA
FY 97 Financial Statement Audit
Contractor Visit - FI & Carrier
Palmetto Government Benefits Administrators (Palmetto)

Financial Reporting
September 30, 1997

Finding 3

Subject:	Accuracy of Submitted HCFA 1522 Prior to Submission in CAFM
Condition:	Our review of the 1522 for September 1997 showed that the contractor inadvertently used the daily report titled "Periodic Interim Payments Made" instead of the monthly report. Although this error did not affect the total amount reported under "PIP Paid" it did change the allocated amount of the various types of PIP payments.
Cause:	We were informed that Supervisory review of the HCFA 1522 is performed prior to submission in CAFM but that an error had occurred in the preparation of the September, 1997 report.
Criteria:	The HCFA 1522 should accurately reflect the actual results for that period.
Effect:	The inaccuracy does not appear to have had any material effect on the final HCFA 1522 but the breakdown of the PIP amounts should be accurately reflected.
Contractor Response:	We do agree there was an error in the preparation of the HCFA 1522 Part A for the month of September 1997 in regards to the breakdown of the PIP payments for the month. We have controls in place to ensure this does not happen again by checking INFOPAC (an on-line storage computer system for report distribution) during the supervisory review to verify the reports being used for the 1522 are correct. This takes place prior to the transmission to HCFA on CAFM. We would like to make sure it is known that this error had no effect on the total amount reported under PIP Paid. It only had an effect on the allocation of the PIP payments for this particular month and therefore had no material effect on the final total reported on the HCFA 1522 Part A.

HCFA
FY 97 Financial Statement Audit
Contractor Visit - FI & Carrier
Palmetto Government Benefits Administrators (Palmetto)

Accounts Receivable
September 30, 1997

Finding 4

Subject:	Provider Overpayment Report (POR) Reconciliation
Condition:	PGBA does not reconcile the provider overpayment ending balance per its system and manual reports to the detailed PORS report.
Cause:	PBGA performed a reconciliation of the POR at the journal entry level, and felt that other controls were in place to provide assurance that the Provider Overpayment Balance on the POR agrees to the contractor records.
Criteria:	Same or related data from various sources (manual or system, HCFA or Contractor) should be reconciled to ensure that they agree.
Effect:	There is no assurance that the ending detailed balance on PORS agrees to the PGBA's records.
Contractor Response:	Palmetto GBA reconciles new receivable to the POR. This reconciliation is performed to ensure that everything is entered on POR. Collections are keyed to the POR from an FSS report. Effective with quarter ending December 31, 1997, Palmetto GBA will begin reconciling the ending balance on the subsidiary ledger to the POR.

HCFA
FY 97 Financial Statement Audit
Contractor Visit - FI & Carrier
Palmetto Government Benefits Administrators (Palmetto)

Accounts Receivable
September 30, 1997

Finding 5

Subject: Supporting Documentation for Account Receivable

Condition: We were unable to reconcile the lead sheets to supporting documentation for some components of the Accounts Receivable. The following were noted:

Part A (HI and SMI)	Comment
MSP	The ending balance detailed support did not agree to the lead sheet and no reconciliation from the detailed support to the lead sheet was received.
Medical Review (HI)	The detailed support received for the amounts on the lead sheet did not agree to those amounts and no reconciliation between the support and the lead sheets was obtained.
MSP -Subrogation	In a written response received from PBGA dated 12/23/97, it stated detailed information is not readily available and is manually gathered. It will take approximately 4 to 6 weeks to gather the detail information.
Credit Balance	A detailed listing is not available for the adjustment claims that are processed by the Florida Shared System (FSS).
Part B	
MSP	Per PBGA letter dated 12/23/97, detail ledger is available and is in the process of being provided. However, we have not received the materials as of 1/14/98, the last submission day.
Medical Review	No detailed support for all lines on the lead sheet (New Receivables, Collections, Reclass, and Ending Balance) as of 1/14/98.

Cause: See comment and response sections.

Criteria: Amounts reported on the HCFA 750 for Accounts Receivable should be adequately supported.

Effect: Completeness and validity of accounts receivable reported to HCFA cannot be verified.

Contractor Response: Part A MSP will reconcile the difference between the ending balance detailed support and the lead sheet for the quarter ending December 31, 1997.

Part A Medical Review will be reconciling the subsidiary ledgers for the quarter ending December 31, 1997.

Information needed to provide the MSP subrogation ledger has been manually gathered and entered in spreadsheet format. Work is underway to format and add formulas to this data to provide summary information. Completion is anticipated by March 31, 1998. Once complete, this dataset will be continually updated to reflect new receivables and collections.

Contractor Response: A detailed listing is not available for the adjustment claims that are processed by the Florida Shared System (FSS). Negative payment claims are usually collected immediately. The balance on any claims not collected are carried forward until the full collection is made from the provider's payment. FSS reports monthly on the on the adjustment claim processed and the monthly collections.

Part B MSP will ensure detailed ledgers that support the ending balance are in place for quarter ending December 31, 1997.

In regards to the subsidiary ledgers for the Part B Medical Review accounts receivable, the carrier inadvertently reported "established MR/UR overpayments" in both the Part B overpayment receivables and the potential MR/UR overpayment columns. The subsidiary ledger for the Part B overpayments includes the $168,823.33 reported for Medical Review. The actual potential MR/UR overpayment amount should have been $0.00 as there were no open cases at the end of the fourth quarter. This problem has been rectified and we placed procedures in effect to ensure that it does not reoccur.

HCFA
FY 97 Financial Statement Audit
Contractor Visit - FI & Carrier
Palmetto Government Benefits Administrators (Palmetto)

Cash Receipts
September 30, 1997

Finding 6

Subject:	Timely Recording of Receipts
Condition:	One of the 30 cash receipts reviewed was not recorded timely and applied to accounts receivable. The receipt was for a Medicare Secondary Payer (MSP) liability and was deposited on 8/29/97 but still have not been recorded in the shared system as of 1/13/98.
Cause:	It is the policy of the Contractor to delay the recording of the liability related deposits until the final demand determination has been made.
Criteria:	General Accounting Office Standards for Internal Controls state that transactions should be promptly recorded, properly classified, and accounted for in order to prepare timely accounts and other reports.
Effect:	The information reflected in the system does not reflect all available data.
Contractor Response:	This receipt was related to an open liability file and was not "worked" as of the date of the audit. Palmetto have recently (10/17/97) replaced the person that had the responsibility for this workload and there is currently an aged backlog in it. The aged backlog of this activity has been readily reported in all department monthly reports. Palmetto has a plan of action and target date of April 1, 1988 to have the backlog eliminated.

HCFA
FY 97 Financial Statement Audit
Contractor Visit - FI & Carrier
Palmetto Government Benefits Administrators (Palmetto)

Accounts Payable - Claims on Payment Floor
September 30, 1997

Finding 7

Subject:	No Subsidiary Ledgers for DMERC Claims on Payment Floor
Condition:	Palmetto failed to provide the subsidiary ledgers to support the DMERC Claims on Payment Floor of $54,746,486.76 at 9/30/97.
Cause:	The contractor does not routinely generate this report, and became aware of the auditors' need for this schedule only after September 30, 1997. Because of system's limitation, generating this report will require time consuming efforts.
Criteria:	GAO Standards for Internal Controls state that "documentation of transactions or other significant events should be complete and accurate, and should facilitate tracing the transaction or event and related information from before it occurs, while it is in process, or after it is completed."
Effect:	There is no assurance that the amounts reported is complete. The subsidiary ledgers total can not be reconciled to the reported amount.
Contractor Response:	Palmetto has added to their routine procedures to produce the subsidiary ledgers each quarter. The detail report will be balanced to the total Claims on the Payment Floor. The detail report will be maintained along with the report of the total of DMERC Claims on the Payment Floor. Palmetto followed these procedures for the quarter ending 12/31/97 and the reports were in balance. No further corrective actions are needed.

Medicare

Palmetto Government Benefits Administrators

Post Office Box 100190
Columbia, South Carolina 29202-3190

June 26, 1998

Charles J. Curtis, Regional Inspector General for Audit Services
US DHHS Office of Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW Room 3T41
Atlanta, Georgia 30303-8909

Re: Response to Draft Report (*Assist Audit of HCFA's FY 1997 Financial Statements at Palmetto Government Benefits Administrators*)
CIN: A-04-98-03009

Dear Mr. Curtis:

The Palmetto Government Benefits Administrators response to the independent auditors (Clifton Gunderson, L.L.C.) concerning the EDP controls was inadvertently omitted from my letter to you of June 25, 1998. Only the response to the findings involving the non-claims disbursements was included.

The response to the findings pertaining to EDP are enclosed. I regret having neglected to include this document with the original correspondence.

If there are any questions, or if I may be of further assistance, please call me at (803)788-0222, ext. 38143.

Sincerely,

E. Ray Bair, CFE
Director, Government Programs Compliance

1 Enclosure

cc: Carol Nicholson, HCFA CO
William R. Horton, PGBA
Ann Archibald, PGBA
Lisa Killian, PGBA
Susan McGuirt, PGBA
Sue Pearcy, PGBA
Roz Catoe, PGBA
Robin Spires, PGBA
Don Wells, PGBA
Bill Crews, PGBA
Barbara Excell, PGBA
Leon Myers, PGBA
John Dart, PGBA

DEPARTMENT OF HEALTH & HUMAN SERVICES
Office of Inspector General
Washington, D.C. 20201

February 13, 1998

Mr. William R. Horton
Group Vice President
Government Programs
Blue Cross Blue Shield of South Carolina
I-20 at Alpine Road
Columbia, South Carolina 29219

Dear Mr. Horton,

The independent public accounting firm of Clifton Gunderson (CG) LLC under contract with the Department of Health and Human Services (HHS) Office of Inspector General (OIG) has completed its information systems review at Blue Cross Blue Shield of South Carolina. Their review was an Electronic Data Processing (EDP) general controls review without program change and an application controls review of VMS.

We have enclosed our final report which incorporates the finding and recommendation resulting from CG's review. The report includes the formal management response which indicates that you have already taken corrective action.

These reviews are a critical part of the Health Care Financing Administration's financial statement audit for the year ending September 30, 1997. We have been informed by the CG audit team that they could not have completed their review without the excellent cooperation extended by your staff.

If you have any questions or would like to let us know of your progress in improving your EDP operations, please don't hesitate to call Jerry Hammond at (410) 786-2130 or Bruce Randle at (410) 786-9232.

Sincerely,

Janet S. Rankin
Director, Audit Operations &
Financial Statement Activities

Enclosure

cc: See page 2

Blue Cross Blue Shield of South Carolina

Bruce W. Hughes
Bruce Havens ✓

HCFA Central Office

Gary Christoph - Office of Information Systems - Director
Peter Koza
Jerry Mulcahy
Carol Nicholson
Marianne Faulstitch
Marybeth Jason

HCFA Regional Office

Rose Crum-Johnson - Regional Administrator
Wilma Cooper - Regional Audit Coordinator

OIG Regional Office

Ballard Hillman
Wayne Griffin
Tom Justice
Larry Jacobson

OIG Headquarters

Ed Meyers
Steve Greenfield

General Accounting Office

Carol Langelier
William Thompson

Ernst & Young

Gerard Reyes

Clifton Gunderson

Gerald DeCosta

BlueCross BlueShield
of South Carolina

An Independent Licensee
of the Blue Cross and
Blue Shield Association

I-20 at Alpine Road
Columbia, S.C. 29219-0001
803-788-0222

December 10, 1997

Mr. Gerald DeCosta
Clifton Gunderson, L.L.C.
7833 Walker Drive, Suite 440
Greenbelt, MD 20770

Dear Mr. DeCosta:

I am sorry for the delay in providing the following *formal* management response:

> Management concurs with the audit finding titled Service Continuity presented in the exit conference held in Palmetto Government Benefits Administrator's offices on September 26, 1997. This finding has been corrected with the distribution of the final audit evaluation report of Medicare Part B and DMERC Systems Disaster Recovery Test, issued on October 24, 1997. Copies were forwarded to Clifton Gunderson, Office of Inspector General, and Health Care Financing Administration on October 29, 1997.

If you have any questions please call me at (803) 788-0222 ext. 42204.

Sincerely,

Bruce D. Havens

Bruce D. Havens, CIA
Manager I/S Audit

cc: Ann Archibald
Bill Horton
Bruce Hughes
Charlie Higgins
Dickie Butler
✓Lisa Killian

Clifton
Gunderson L.L.C.
Certified Public Accountants & Consultants

Golden Triangle I
7833 Walker Drive, Suite 440
Greenbelt, Maryland 20770
(301) 345-0500
(301) 345-0054 Fax
www.cliftoncpa.com

December 1, 1997

Bruce Havens
Blue Cross Blue Shield of South Carolina
Internal Auditing Department
1-20 at Alpine Road
Columbia, S.C. 29219-0001

Dear Bruce:

Thank you for taking time to assist us in our EDP review at Blue Cross Blue Shield of South Carolina (BCBS-SC). We have attached the draft audit report for the EDP general and application controls review which contains our finding and recommendation as we discussed during the exit conference on September 26, 1997.

We are in receipt of your Disaster Recovery Test evaluation report. However, please provide BCBS-SC's *formal* management responses indicating whether or not you agree with the finding and whether or not the finding accurately portrays the evaluation of your firms internal control relative to the finding, by December 15, 1997. Please also acknowledge that you received from us at the exit conference a draft of the preliminary finding. Your responses will be incorporated into the draft report and a final report will be issued by December 31, 1997.

If you have any questions related to our findings and recommendations please call me at (301) 345-0500. I look forward to receiving your audit responses and thank you again for your time.

Sincerely,

Gerald DeCosta
Federal Contracts Manager
Clifton Gunderson L.L.C.

Attachment

cc: Jerry Hammond, DHHS Office of Inspector General
Carol Nicholson, HCFA Central Office

BlueCross BlueShield
of South Carolina

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of the Blue Cross and
Blue Shield Association

I-20 at Alpine Road
Columbia, S.C. 29219-0001
803-788-0222

October 29, 1997

Mr. Gerald DeCosta
Clifton Gunderson, L.L.C.
7833 Walker Drive, Suite 440
Greenbelt, MD 20770

Dear Mr. DeCosta:

I am sending you a copy of the final report on the Medicare Part B / DMERC Systems Disaster Recovery Test performed in May 1997. This is in response to the finding issued by Clifton Gunderson during your review of Palmetto Government Benefits Administrators on behalf of the Office of the Inspector General.

If you have any questions please call me at (803) 788-0222 ext. 42204.

Sincerely,

Bruce D. Havens

Bruce D. Havens, CIA
Manager I/S Audit

Attachment

cc: Bruce Randle, Audit Manager CFO Staff
Jerry Hammond, HCFA Central Office
Norma Jo Bales, HCFA Regional Office

cc no attachment:
Bill Horton
Bruce Hughes
Ann Archibald
Charles Higgins
✓Lisa Killian