Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE CLAIMS SUBMITTED BY A CARDIOLOGIST IN NEW YORK STATE

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Inspector General

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The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Medicare program, established under Title XVIII of the Social Security Act (the Act) in 1965, provides health insurance to people age 65 and over, to those suffering from permanent kidney failure, and to certain people with disabilities. The Medicare Part B program is administered by the Centers for Medicare & Medicaid Services, which contracts with local carriers to pay for cardiology and other medical services.

Section 1861(q) of the Act describes physician services as professional services performed by physicians, including surgery; consultation; and home, office, and institutional calls. Medicare reimbursement for physician services is made on the basis of a fee schedule, which is a predetermined payment amount set forth by law. Pursuant to section 1862(a)(1)(A) of the Act, no payment may be made under Medicare Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. In addition, section 1833(e) of the Act prohibits payment for services unless the provider furnishes such information as may be necessary in order to determine the amounts due.

For the period January 1, 2005, through December 31, 2007, a cardiologist located in New York State claimed Medicare payments totaling $1,367,954 for 5,061 claims.

OBJECTIVE

Our objective was to determine if the claims submitted by a cardiologist located in New York State complied with Medicare reimbursement requirements.

SUMMARY OF RESULTS

For the three-year period ending December 31, 2007, claims submitted by the cardiologist complied with Medicare reimbursement requirements. As a result, this report contains no recommendations.

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Medicare Program

The Medicare program, established under Title XVIII of the Social Security Act (the Act) in 1965, provides health insurance to people age 65 and over, to those suffering from permanent kidney failure, and to certain people with disabilities. The Medicare Part B program is administered by the Centers for Medicare & Medicaid Services (CMS), which contracts with local carriers to pay for cardiologist and other medical services.

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Cardiologist

For the period January 1, 2005, through December 31, 2007, a cardiologist located in New York State claimed Medicare payments totaling $1,367,954 for 5,061 claims. The cardiologist, who specialized in non-invasive cardiology procedures, had a high volume of Medicare claims in comparison to other cardiologists throughout New York State.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if the claims submitted by a cardiologist located in New York State complied with Medicare reimbursement requirements.

Scope

Our audit period covered January 1, 2005, through December 31, 2007. We did not review the medical necessity or reasonableness of the services claimed. In addition, we did not review the overall internal control structure of the cardiologist's practice. Rather, we limited our review to the practice's procedures relevant to the objective of the audit.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- interviewed the cardiologist and his staff to gain an understanding of the cardiologist's procedures for submitting Medicare claims;

- extracted 5,061 Medicare claims, totaling $1,367,954, paid to the cardiologist during our audit period from the CMS National Claims History database;

- selected a simple random sample of 100 of the 5,061 paid Medicare claims, totaling $28,348; and for each sample item:

    - determined if recipient was enrolled in the Medicare program;

    - reviewed supporting documentation to determine if the related service was actually provided; and

    - determined if the related service was claimed at the correct rate.

We conducted our review in accordance with generally accepted government audit standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

RESULTS OF REVIEW

For the three-year period ending December 31, 2007, claims submitted by the cardiologist complied with Medicare reimbursement requirements. As a result, this report contains no recommendations.