DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

August 19, 2009

Report Number: A-05-09-00063

Mr. Rodney Woods
President and Chief Executive Officer
Riverbend Government Benefits Administrator
730 Chestnut Street
Chattanooga, Tennessee 37402

Dear Mr. Woods:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Riverbend Government Benefits Administrator Medicare Payments to Providers Terminated From January 1, 2003, Through January 31, 2007." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact David Markulin, Audit Manager, at (312) 353-1644 or through email at David.Markulin@oig.hhs.gov. Please refer to report number A-05-09-00063 in all correspondence.

Sincerely,

Marc Gustafson
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF RIVERBEND GOVERNMENT BENEFITS ADMINISTRATOR MEDICARE PAYMENTS TO PROVIDERS TERMINATED FROM JANUARY 1, 2003, THROUGH JANUARY 31, 2007

Daniel R. Levinson
Inspector General

August 2009
A-05-09-00063

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries (FI) to process and pay Medicare claims submitted by health care providers.

The FIs must comply with Medicare regulations and policies, including those related to processing payments to terminated Medicare providers. Section 1814(a) of the Act provides that " . . . payment for services furnished an individual may be made only to providers of services which are eligible therefore under section 1866 [which sets forth the requirements for provider agreements] . . . ." The CMS Pub. No. 100-06, "Medicare Financial Management Manual," chapter 7, requires FIs to maintain adequate internal controls to prevent increased program costs and erroneous payments. Chapter 3, section 10.2, of the manual states, "An individual overpayment is an incorrect payment for provider or physician services made under title XVIII. Examples . . . are . . . payment for items or services rendered during a period of non-entitlement [e.g. periods for which a provider agreement was not in effect]." Section 20.2 further states, "If the FI discovers an overpayment . . ., with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund . . . ."

Riverbend Government Benefits Administrator (Riverbend), a FI, provides a broad range of services including claims processing and payment, customer service, and provider education and outreach. For our audit period January 1, 2003, through January 31, 2007, CMS terminated 313 providers serviced by Riverbend.

OBJECTIVE

Our objective was to determine whether Riverbend made unallowable payments for services that were furnished on or after the dates that the providers were terminated from the Medicare program.

SUMMARY OF FINDING

Prior to our audit, Riverbend had not recovered $173,617 in unallowable payments made to 13 providers for 2,783 claims that were not eligible for payment because the services were provided on or after the dates that the providers were terminated from the Medicare program. Riverbend had not recovered $13,751 because it was unaware that two providers had been terminated from the Medicare program. Riverbend had not recovered the remaining $159,866 primarily because it did not follow its procedures to retroactively identify the unallowable payments. Riverbend confirmed the payments were unallowable and subject to recovery.

RECOMMENDATIONS

We recommend that Riverbend:

- recover $173,617 in unallowable payments made to the 13 terminated Medicare providers and

- follow its procedures to retroactively identify and recover unallowable payments for claims with dates of service on or after the providers' effective termination dates.

RIVERBEND COMMENTS

In written comments to our draft report, Riverbend said that it adjusted the claims identified during the audit and has updated its procedures to identify claims paid after a provider's termination date. Riverbend's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Medicare Program

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with fiscal intermediaries (FI) to process and pay Medicare claims submitted by health care providers. Pursuant to sections 1814(a) and 1866 of the Act, Medicare reimbursement is generally limited to participating providers that have entered into and maintain provider agreements, which set forth the terms and conditions for participation in the Medicare program. Terminated providers generally can not continue to participate in the Medicare program after their effective termination dates.

Medicare Payment Requirements

Section 1814(a) of the Act provides that ". . . payment for services furnished an individual may be made only to providers of services which are eligible therefore under section 1866 [which sets forth the requirements for provider agreements] . . . ." The CMS Pub. No. 100-06, "Medicare Financial Management Manual," chapter 7, requires FIs to maintain adequate internal controls to prevent increased program costs and erroneous payments. Chapter 3, section 10.2, of the manual states, "An individual overpayment is an incorrect payment for provider or physician services made under title XVIII. Examples . . . are . . . payment for items or services rendered during a period of non-entitlement [e.g. periods for which a provider agreement was not in effect]." Section 20.2 further states, "If the FI discovers an overpayment . . ., with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund . . . ."

Riverbend Government Benefits Administrator

Riverbend Government Benefits Administrator (Riverbend), a FI, provides a broad range of services including claims processing and payment, customer service, and provider education and outreach. For our audit period January 1, 2003, through January 31, 2007, CMS terminated 313 providers serviced by Riverbend.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Riverbend made unallowable payments for services that were furnished on or after the dates that the providers were terminated from the Medicare program.

Scope

We reviewed all Riverbend payments for services provided by 13 providers after CMS terminated them from the Medicare program during the period from January 1, 2003, through January 31, 2007. We limited our review of internal controls to discussing the procedures used to retroactively identify and recover unallowable payments to terminated Medicare providers.

We performed fieldwork by contacting Riverbend in Chattanooga, Tennessee.

Methodology

To accomplish the objective we:

- obtained a CMS nationwide list of 4,647 Medicare providers that were terminated on dates during the audit period,
- queried the National Claims History file to identify potentially unallowable Medicare payments made by Riverbend to terminated providers for services that were provided on or after the providers' effective termination dates, and
- identified providers that each received $5,000 or more in potentially unallowable payments and obtained additional information from Riverbend and CMS to
    - determine whether the payments were unallowable and subject to recovery and
    - quantify the unallowable payments.

We conducted this performance audit in accordance with generally accepted government auditing 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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Prior to our audit, Riverbend had not recovered $173,617 in unallowable payments made to 13 providers for 2,783 claims that were not eligible for payment because the services were provided on or after the dates that the providers were terminated from the Medicare program. Riverbend had not recovered $13,751 because it was unaware that two providers had been terminated from the Medicare program. Riverbend had not recovered the remaining $159,866 primarily because it did not follow its procedures to retroactively identify the unallowable payments. Riverbend confirmed the payments were unallowable and subject to recovery.

MEDICARE PAYMENTS TO TERMINATED PROVIDERS

Prior to our audit, Riverbend had not recovered $173,617 paid to 13 providers for 2,783 claims that were not eligible for payment because the services were provided on or after the effective dates that the providers were terminated from the Medicare program.

Federal Requirements

Pursuant to sections 1814(a) and 1866 of the Act, Medicare reimbursement is generally limited to participating providers that have entered into and maintain provider agreements, which set forth the terms and conditions for participation in the Medicare program. Section 1814(a) of the Act provides that ". . . payment for services furnished an individual may be made only to providers of services which are eligible therefore under section 1866 . . . ."

The CMS Pub. No. 100-06, "Medicare Financial Management Manual," chapter 7, requires FIs to maintain adequate internal controls to prevent increased program costs and erroneous payments. Chapter 3, section 10.2, of the manual states, "An individual overpayment is an incorrect payment for provider or physician services made under title XVIII. Examples . . . are . . . payment for items or services rendered during a period of non-entitlement [e.g. periods for which a provider agreement was not in effect]." Section 20.2 further states, "If the FI discovers an overpayment . . ., with respect to a provider no longer participating in Medicare, it shall immediately contact the terminated provider to obtain a refund . . . ."

Unallowable Payments Not Recovered

Thirteen providers received unallowable Medicare payments for services that were performed on or after the effective dates that the providers were terminated from the Medicare program.

Table: Unallowable Claims and Payments

	Unallowable Claims	Unallowable Payments
Provider A	634	$36,273
Provider B	521	35,381
Provider C	259	16,769
Provider D	298	15,577
Provider E	165	10,299
Provider F	151	9,222
Provider G	168	9,090
Provider H	158	8,162
Provider I	139	7,793
Provider J	2	7,016
Provider K	148	6,817
Provider L	36	5,958
Provider M	104	5,260
Total	**2,783**	**$173,617**

Riverbend had not recovered $13,751 paid to providers I and L because it was unaware that these providers had been terminated from the Medicare program.[1] Riverbend had not recovered the remaining $159,866 paid to the remaining 11 providers primarily because it did not follow its procedures to retroactively identify the unallowable payments.

RECOMMENDATIONS

We recommend that Riverbend:

- recover $173,617 in unallowable payments made to the 13 terminated Medicare providers and

- follow its procedures to retroactively identify and recover unallowable payments for claims with dates of service on or after the providers' effective termination dates.

RIVERBEND COMMENTS

In written comments to our draft report, Riverbend said that it adjusted the claims identified during the audit and has updated its procedures to identify claims paid after a provider's termination date. Riverbend's comments are included in their entirety as the Appendix.

[1]Riverbend stated that it had not received termination documents for these providers prior to our audit.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES
www.cms.gov

Medicare
Part A Intermediary

July 29, 2009

Mr. Marc Gustafson
OIG Office of Audit Services
Region V
233 North Michigan Avenue
Chicago, IL 60601

RE: Report Number A-05-09-00063
Review of Riverbend Government Benefits Administrator Medicare Payments to Providers Terminated from January 1, 2003, through January 31, 2007

Dear Mr. Gustafson:

On behalf of Riverbend Government Benefits Administrator (Riverbend), I would like to thank the Office of Inspector General for the opportunity to comment on your findings. Within the context of the authority and funding made available to us as a contractor, Riverbend is committed to assist the Centers for Medicare and Medicaid Services (CMS) in identifying and reducing the Medicare Program's vulnerability to reimbursements of inappropriate claims for payments to providers. We consider the information contained in this review as important feedback that we will use in assessing our processes as part of our continuous improvement commitment.

In order to recoup the overpayments to terminated providers, Riverbend has adjusted the claims identified during the audit. Additionally, we have updated our procedures to streamline the process of identifying claims paid after a provider's termination date.

If you have any questions or need additional information, you may contact me at (423)535-4243 or via e-mail at john.hayes@rgbagov.com.

Best Regards,

J. HAYES
John R. Hayes
Chief Operating Officer
Riverbend Government Benefits Administrator