Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY WISCONSIN PHYSICIANS SERVICE INSURANCE CORPORATION BUT TRANSITIONED TO PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR IN JURISDICTION 1 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General

August 2012
A-07-11-04182

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:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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 Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with Medicare contractors to process and pay Medicare claims submitted for outpatient services. The Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description. In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

During our audit period (January 2006 through June 2009), Wisconsin Physicians Service Insurance Corporation (WPS) processed approximately 43.8 million line items for outpatient services in Jurisdiction 1, of which 347 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service. Effective April 2010, the claims that were originally processed by WPS in Jurisdiction 1 were transitioned to Palmetto Government Benefits Administrator (Palmetto). Thus, the 347 line items will be adjudicated by Palmetto, and we are issuing our report to Palmetto. (A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges.") We reviewed only 344 of the 347 line items because 1 provider associated with 3 line items was in bankruptcy.

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges that WPS made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 344 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 59 were correct. Providers refunded overpayments on five line items totaling $138,360 before our fieldwork. The remaining 280 line items were incorrect and included overpayments totaling $2,205,247, which the providers had not refunded by the beginning of our audit. (As of May 8, 2012, Palmetto had not recovered overpayments totaling $937,414 from 9 providers associated with 120 of the 280 incorrect line items; see Appendix A.)

Of the 280 incorrect line items:

- Providers reported incorrect units of service on 260 line items, resulting in overpayments totaling $1,945,369. (This amount includes overpayments for 109 of the 260 line items that had not been recovered.)

- Providers did not provide the supporting documentation for nine line items, resulting in overpayments totaling $156,044. (This amount includes overpayments for eight of the nine line items that had not been recovered.)

- Providers used HCPCS codes that did not reflect the procedures performed on three line items, resulting in overpayments totaling $85,430. (Palmetto has recovered the full amount of overpayments associated with these three line items.)

- Providers billed for unallowable services on two line items, resulting in overpayments totaling $15,108. (This amount includes an overpayment for one of the two line items that had not been recovered.)

- Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on six line items, resulting in overpayments totaling $3,296. (This amount includes overpayments for two of the six line items that had not been recovered.)

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that Palmetto:

- recover the $2,205,247 in identified overpayments by:

    - verifying that recovery occurred for $1,267,833 in overpayments and

- issuing demand letters to the 9 providers that had not refunded the 120 line items totaling $937,414 in identified overpayments,

- work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and

- use the results of this audit in its provider education activities.

PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR COMMENTS

In written comments on our draft report, Palmetto stated that $1,267,833 of the $2,205,247 in identified overpayments had been recovered. In addition, Palmetto stated that demand letters would be issued after receipt of our final report to recover the remaining 120 line items totaling $937,414 in identified overpayments.

Palmetto also described corrective actions that it had taken or planned to take in response to our other recommendations.

Palmetto's comments are included in their entirety as Appendix B.

TABLE OF CONTENTS

Page

INTRODUCTION 1

BACKGROUND 1
Medicare Contractors 1
Claims for Outpatient Services 1
Wisconsin Physicians Service Insurance Corporation 2

OBJECTIVE, SCOPE, AND METHODOLOGY 2
Objective 2
Scope 2
Methodology 3

FINDINGS AND RECOMMENDATIONS 3

FEDERAL REQUIREMENTS 4

OVERPAYMENTS FOR SELECTED LINE ITEMS 5
Incorrect Number of Units of Service 5
Unsupported Services 5
Incorrect Healthcare Common Procedure Coding System Codes 5
Services Not Allowable for Medicare Reimbursement 6
Combination of Incorrect Number of Units of Service and
Incorrect Healthcare Common Procedure Coding System Codes 6

CAUSES OF INCORRECT MEDICARE PAYMENTS 6

RECOMMENDATIONS 7

PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR COMMENTS 7

APPENDIXES

A: OVERPAYMENTS BY PROVIDERS NOT RECOVERED

B: PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR COMMENTS

INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted for outpatient services.[1] The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. To process providers' outpatient claims, the Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description.[2] In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

[1] Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

[2] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

Wisconsin Physicians Service Insurance Corporation

As part of its Legacy Workload, Wisconsin Physicians Service Insurance Corporation (WPS) processed some outpatient claims for Jurisdiction 1 during our audit period (January 2006 through June 2009).[3] Effective April 2010, the Legacy Jurisdiction 1 (Legacy J1) Workload transitioned to Palmetto Government Benefits Administrator (Palmetto), the Medicare contractor for all States in Jurisdiction 1—California, Hawaii, and Nevada—and the territories of American Samoa, Guam, and the Northern Mariana Islands.[4] Thus, the Legacy J1 claims that were originally processed by WPS will be adjudicated by Palmetto, and we are issuing our report to Palmetto. During our audit period, WPS processed 43.8 million line items for outpatient services that were transitioned to Palmetto.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges that WPS made to providers for outpatient services were correct.

Scope

Of the approximately 43.8 million line items for outpatient services that WPS processed during the period January 2006 through June 2009, 347 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service.[5] We reviewed only 344 of the 347 line items because 1 provider associated with 3 line items was in bankruptcy.

We limited our review of WPS's and Palmetto's internal controls to those that were applicable to the selected payments because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

[3] The WPS Legacy Workload had previously been processed by Mutual of Omaha. The Legacy Workload includes claims submitted by providers who fall under the geographic jurisdiction of all 15 MACs.

[4] The Legacy Workload transition includes a significant number of providers that are Qualified Chain Providers, a designation for providers located over a large geographic area that belong to multiple MAC jurisdictions. A Qualified Chain Provider has the option to move all of its providers, regardless of geographic location, to the MAC that covers the State in which the Qualified Chain Provider's home office is located.

[5] A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these two criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges."

Our fieldwork included contacting WPS in Omaha, Nebraska, as well as Palmetto in Camden, South Carolina, and the 40 providers in Jurisdiction 1 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items processed by WPS for providers that billed line items with (1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000 and (2) 3 or more units of service;[6]
- coordinated with WPS and Palmetto in determining the providers and line items associated with the Legacy J1 Workload;
- identified 347 line items (we did not review 3 line items because the provider was in bankruptcy) totaling approximately $2.9 million that Medicare paid to 40 providers;
- contacted the 40 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with Palmetto; and
- provided the results of our review to Palmetto officials on May 14, 2012.

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 findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 344 selected line items for which WPS made Medicare payments to providers for outpatient services during our audit period, 59 were correct. Providers refunded overpayments

[6] For this audit, we reviewed those line items that met the stated parameters. We applied those parameters to unadjusted line items. In some cases, subsequent payment adjustments reduced the difference between payment and charges to less than $1,000.

on five line items totaling $138,360 prior to our fieldwork. The remaining 280 line items were incorrect and included overpayments totaling $2,205,247, which the providers had not refunded by the beginning of our audit. (As of May 8, 2012, Palmetto had not recovered overpayments totaling $937,414 from 9 providers associated with 120 of the 280 incorrect line items; see Appendix A.)

Of the 280 incorrect line items:

- Providers reported incorrect units of service on 260 line items, resulting in overpayments totaling $1,945,369. (This amount includes overpayments for 109 of the 260 line items that had not been recovered.)

- Providers did not provide the supporting documentation for nine line items, resulting in overpayments totaling $156,044. (This amount includes overpayments for eight of the nine line items that had not been recovered.)

- Providers used HCPCS codes that did not reflect the procedures performed on three line items, resulting in overpayments totaling $85,430. (Palmetto has recovered the full amount of overpayments associated with these three line items.)

- Providers billed for unallowable services on two line items, resulting in overpayments totaling $15,108. (This amount includes an overpayment for one of the two line items that had not been recovered.)

- Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on six line items, resulting in overpayments totaling $3,296. (This amount includes overpayments for two of the six line items that had not been recovered.)

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

FEDERAL REQUIREMENTS

Section 1833(e) of the Social Security Act states: "No payment shall be made to any provider of services … unless there has been furnished such information as may be necessary in order to determine the amounts due such provider … for the period with respect to which the amounts are being paid …."

CMS's *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: "providers must use HCPCS codes … for most outpatient services." Chapter 25, section 75.5, of the Manual states: "… when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was

performed."[7] If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, "[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4 …."

Chapter 1, section 80.3.2.2, of the Manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported an incorrect number of units of service on 260 line items, resulting in overpayments totaling $1,945,369. (This amount includes overpayments for 109 of the 260 line items that had not been recovered.) The following examples illustrate the incorrect units of service:

- One provider billed Medicare for an incorrect number of units of service on 29 line items. Rather than billing for 1 service unit for a gastrointestinal endoscopy, the provider billed between 6 and 61 service units. These errors occurred because of an incorrect multiplier in the provider's billing system. As a result of these errors, WPS paid the provider $203,924 when it should have paid $10,390, an overpayment of $193,534.

- Another provider billed Medicare for an incorrect number of units of service on 31 line items. Rather than billing 100 service units, the provider billed 10,000 service units. These errors occurred because of an incorrect multiplier in the provider's billing system. As a result of these errors, WPS paid the provider $92,480 when it should have paid $924, an overpayment of $91,556.

Unsupported Services

Three providers billed Medicare for nine line items for which they did not provide supporting documentation. As a result of these errors, WPS paid the providers $156,044 when it should have paid $0. (This amount includes overpayments for eight of the nine line items that had not been recovered.)

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on three line items, resulting in overpayments totaling $85,430. (Palmetto has recovered the full amount of overpayments associated with these three line items.)

For example, because of human error, one provider billed Medicare for one line item with a HCPCS code (C9225) for the injection of fluocinolone acetonide, rather than using the correct

[7] Before CMS Transmittal 1254, Change Request 5593, dated May 25, 2007, and effective June 11, 2007, this provision was located at chapter 25, section 60.5, of the Manual.

HCPCS code (J0150) for the injection of adenosine for therapeutic use. As a result of this error, WPS paid the provider $76,433 when it should have paid $104, an overpayment of $76,329.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for two line items for which the services rendered were not allowable for Medicare reimbursement, resulting in overpayments totaling $15,108. (This amount includes an overpayment for one of the two line items that had not been recovered.)

For example, one provider billed Medicare for one line item that was unrelated to outpatient services. Specifically, the provider incorrectly billed Medicare outpatient services for a dental procedure that is not covered by Medicare. For this procedure, the provider billed for the surgical removal of an erupted tooth, which is not a covered procedure according the *Medicare Benefit Policy Manual* (Pub. No. 100-02, chapter 15, section 150). As a result of this error, WPS paid the provider $9,142 when it should have paid $0, an overpayment of $9,142.

Combination of Incorrect Number of Units of Service and Incorrect Healthcare Common Procedure Coding System Codes

Providers reported a combination of incorrect number of units of service claimed and incorrect HCPCS codes on six line items. These errors resulted in overpayments totaling $3,296. (This amount includes overpayments for two of the six line items that had not been recovered.)

For example, one provider billed Medicare for both the incorrect number of units of service and incorrect HCPCS codes on one line item. Rather than billing for 1 service unit of a gastrointestinal endoscopy procedure (HCPCS code 43246), the provider billed 61 service units for the repositioning of a feeding tube (HCPCS code 43761). As a result of these errors, WPS paid the provider $12,556 when it should have paid $405, an overpayment of $12,151.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. WPS made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.[8]

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires Medicare contractors to determine the legitimacy of the claims. However, this edit did not detect the errors that we found because the edit considers only the amount of the payment,

[8] The Medicare contractor sends a *Medicare Summary Notice*—an explanation of benefits—to the beneficiary after the provider files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

suspends only those payments that exceed the threshold, and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that Palmetto:

- recover the $2,205,247 in identified overpayments by:
    - verifying that recovery occurred for $1,267,833 in overpayments and
    - issuing demand letters to the 9 providers that had not refunded the 120 line items totaling $937,414 in identified overpayments,
- work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR COMMENTS

In written comments on our draft report, Palmetto stated that $1,267,833 of the $2,205,247 in identified overpayments had been recovered. In addition, Palmetto stated that demand letters would be issued after receipt of our final report to recover the remaining 120 line items totaling $937,414 in identified overpayments. (We provided Palmetto with a listing of the 120 line items supporting the overpayment amounts, for its use in the development of the demand letters, on July 3, 2012.)

Palmetto also described corrective actions that it had taken or planned to take in response to our other recommendations.

Palmetto's comments are included in their entirety as Appendix B.

APPENDIXES

APPENDIX A: OVERPAYMENTS BY PROVIDERS NOT RECOVERED

As of May 8, 2012, Palmetto Government Benefits Administrator had not recovered overpayments totaling $937,414 from 9 providers associated with 120 of the 280 incorrect line items. The table below presents a detailed breakdown of the overpayments by provider that, as of May 8, 2012, had not been refunded. We determined that either the selected line items associated with these nine providers had not been adjusted or Palmetto had not processed the adjustments.

Provider	Overpayment
Centinela Hospital Medical Center	$836,509
Rancho Specialty Hospital	31,118
Doctors Medical Center San Pablo	23,540
Pacifica Hospital of the Valley	13,341
Centinela Freeman Regional Medical Center	11,477
Northeastern Nevada Regional Hospital	6,717
Greater El Monte Community Hospital	6,143
University of Southern California Norris Cancer Hospital	5,116
Saint John's Regional Medical Center of Oxnard, California	3,453
Total	**$937,414**

APPENDIX B: PALMETTO GOVERNMENT BENEFITS ADMINISTRATOR COMMENTS

Palmetto GBA
PARTNERS IN EXCELLENCE

Walter J. Johnson
President and Chief Operating Officer

July 13, 2012

Mr. Patrick J. Cogley
Office of Inspector General
Office of Audit Services, Region VII
601 East 12th Street, Room 0429
Kansas City, MO 64106

RE: Draft Report No. A-07-11-04182

Dear Mr. Cogley:

This letter is in response to your letter dated June 14, 2012 to Joe Wright, regarding the recent Office of Inspector General (OIG) report entitled "*Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Wisconsin Physicians Service Insurance Corporation but Transitioned to Palmetto GBA in Jurisdiction 1 for the Period January 1, 2006, Through June 30, 2009.*" We appreciate the feedback your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

Palmetto GBA, LLC assumed workload for Wisconsin Physicians Services effective April 2010.

During the audit period 344 line items were selected which WPS made Medicare payments to providers for outpatient services during the audit period, 59 were correct. The remaining 280 line items were incorrect and included overpayments totaling $2,205,247. The 280 incorrect line items had;

- Providers reported incorrect units of service on 260 line items, resulting in overpayments totaling $1,945,369.
- Providers did not provide the supporting documentation for nine line items, resulting in overpayments totaling $156,044.
- Providers used HCPCS codes that did not reflect the procedures performed on three line items, resulting in overpayments totaling $85,430.
- Providers billed for unallowable services on two line items, resulting in overpayments totaling $15,108.
- Providers reported a combination of incorrect number of units of services claimed and incorrect HCPCS codes on six line items, resulting in overpayments totaling $3,296.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of services and other types of billing errors. Because neither the Fiscal Intermediary Standard System (FISS) nor the CWF had sufficient edits in place to prevent or detect the overpayments the following is recommended:

- **Recover the $2,205,247 identified overpayments.**
  - **verify that recovery occurred for $1,267,833**

    Palmetto GBA Response:

    All claims identified in the audit are adjusted.

  - **issuing demand letters to the 9 providers that had not refunded the 120 line items totaling $937,414 in identified overpayments**

    Palmetto GBA Response:

    Demand letters will be issued when the final report is received with a claim listing supporting the overpayment amounts

- **work with CMS to implement system edits that identify line item payments that exceed billed charges by a prescribed amount**

  Palmetto GBA Response:

  Palmetto GBA will work with CMS to implement edits. This may be problematic due to pricers in the FISS system which automatically pays each claim.

- **use the results of this audit in its provider education activities.**

Palmetto GBA Response:

- Correct coding has been and continues to be discussed in each educational session.

Thank you for providing Palmetto GBA with the opportunity to offer feedback regarding your review. If you have any questions, please do not hesitate to contact me at 803-763-1176.

Sincerely

Walter J. Johnson

cc: Amy Drake, COR, CMS
Sandra Brown, CMS
Mike Barlow, Palmetto GBA
Carol Sutton, Palmetto GBA