DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Washington, D.C. 20201

May 3, 2011

TO: Donald M. Berwick, M.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: /George M. Reeb/
Acting Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 1 for the Period January 1, 2006, Through June 30, 2009 (A-09-10-02018)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by Palmetto GBA, LLC (Palmetto), in Jurisdiction 1. We will issue this report to Palmetto within 5 business days.

If you have any questions or comments about this report, please do not hesitate to contact me at (410) 786-7104 or through email at George.Reeb@oig.hhs.gov or Lori A. Ahlstrand, Regional Inspector General for Audit Services, Region IX, at (415) 437-8360 or through email at Lori.Ahlstrand@oig.hhs.gov. Please refer to report number A-09-10-02018.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region IX
90 – 7th Street, Suite 3-650
San Francisco, CA 94103

May 4, 2011

Report Number: A-09-10-02018

Mr. Mike Barlow
MAC J1 Project Manager
Palmetto GBA, LLC
4249 Easton Way, Suite 400
Columbus, OH 43219

Dear Mr. Barlow:

Enclosed is the U.S. Department of Health & Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 1 for the Period January 1, 2006, Through June 30, 2009*. 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.

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. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to contact Tom Lin, Senior Auditor, at (415) 437-8360 or through email at Tom.Lin@oig.hhs.gov, or contact Alice Norwood, Audit Manager, at (415) 437-8360 or through email at Alice.Norwood@oig.hhs.gov. Please refer to report number A-09-10-02018 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. 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, MO 64106

Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICARE PAYMENTS EXCEEDING CHARGES FOR OUTPATIENT SERVICES PROCESSED BY PALMETTO GBA, LLC, IN JURISDICTION 1 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

May 2011
A-09-10-02018

Office of Inspector General

http://oig.hhs.gov

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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 and those who are disabled or have 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 detail 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 units administered. 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.

In September 2008, Palmetto GBA, LLC (Palmetto), assumed full responsibility as the Medicare administrative contractor for Jurisdiction 1 in three States and three territories. During our audit period (January 1, 2006, through June 30, 2009), approximately 187 million line items for outpatient services were processed in Jurisdiction 1, of which 1,323 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. (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.")

OBJECTIVE

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

SUMMARY OF FINDINGS

Of the 1,323 selected line items for which Palmetto made Medicare payments to providers for outpatient services during our audit period, 397 were correct. The remaining 926 line items were

incorrect and included overpayments totaling $7,545,772, which the providers had not refunded by the beginning of our audit.

Of the 926 incorrect line items:

- Providers reported incorrect units of service on 638 line items, resulting in overpayments totaling $6,211,316.

- Providers used HCPCS codes that did not reflect the procedures performed on 186 line items, resulting in overpayments totaling $709,281.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 65 line items, resulting in overpayments totaling $460,290.

- Providers billed for unallowable services on 18 line items, resulting in overpayments totaling $96,314.

- Providers did not provide supporting documentation for 19 line items, resulting in overpayments totaling $68,571.

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. Palmetto 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 $7,545,772 in identified overpayments,

- 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 GBA, LLC, COMMENTS

In written comments on our draft report, Palmetto provided information on actions that it had taken or planned to take to address the recommendations. Palmetto's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare 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 detail 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 units administered.[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.

Palmetto GBA, LLC

In September 2008, Palmetto GBA, LLC (Palmetto), assumed full responsibility as the MAC for Jurisdiction 1 in three States (California, Hawaii, and Nevada) and three territories (American Samoa, Guam, and Northern Mariana Islands).[3] During our audit period (January 1, 2006, through June 30, 2009), approximately 187 million line items for outpatient services were processed in Jurisdiction 1.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

Of the approximately 187 million line items for outpatient services that were processed during the period January 1, 2006, through June 30, 2009, we reviewed 1,323 line items that 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.[4]

We limited our review of 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.

Our fieldwork included contacting Palmetto in Columbia, South Carolina, and the 149 providers in Jurisdiction 1 that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[3] Before September 2008, providers processed Medicare outpatient claims through separate fiscal intermediaries. In September 2008, Palmetto became fully responsible as the MAC for these States and territories and is therefore responsible for collecting any overpayments and resolving the issues related to this audit.

[4] 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."

- used CMS's National Claims History file to identify outpatient line items in which (1) Medicare line payment amounts exceeded the line billed charge amounts by at least $1,000 and (2) the line item had 3 or more units of service;

- identified 1,323 line items totaling approximately $9.8 million that Medicare paid to 149 providers;

- contacted the 149 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

- discussed the results of our review with Palmetto on January 13, 2011.

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 1,323 selected line items for which Palmetto made Medicare payments to providers for outpatient services during our audit period, 397 were correct. The remaining 926 line items were incorrect and included overpayments totaling $7,545,772, which the providers had not refunded by the beginning of our audit.

Of the 926 incorrect line items:

- Providers reported incorrect units of service on 638 line items, resulting in overpayments totaling $6,211,316.

- Providers used HCPCS codes that did not reflect the procedures performed on 186 line items, resulting in overpayments totaling $709,281.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 65 line items, resulting in overpayments totaling $460,290.

- Providers billed for unallowable services on 18 line items, resulting in overpayments totaling $96,314.

- Providers did not provide supporting documentation for 19 line items, resulting in overpayments totaling $68,571.

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. Palmetto 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."[5] 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 incorrect units of service on 638 line items, resulting in overpayments totaling $6,211,316. The following examples illustrate the incorrect units of service:

- One provider billed Medicare for incorrect service units on 72 line items. Rather than billing between 6 and 10 service units (the correct range for the HCPCS codes associated with these line items), the provider billed between 53 and 100 service units. According to the provider, these errors occurred because the provider's computer software was programmed incorrectly. As a result of these errors, Palmetto paid the provider $2,371,609 when it should have paid $202,047, an overpayment of $2,169,562.

- Another provider billed Medicare for incorrect service units on two line items. Rather than billing for 1 service unit on each line item, the provider billed 65 and 73 service

[5] 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.

units, respectively. According to the provider, these errors occurred because the provider billed for the number of operating room minutes to perform the procedure instead of the number of surgical events performed. As a result of these errors, Palmetto paid the provider $76,751 when it should have paid $2,173, an overpayment of $74,578.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 186 line items, resulting in overpayments totaling $709,281. For example, a provider billed Medicare for 15 line items with the HCPCS code for a 65-milligram injection of leuprolide acetate implant rather than using the correct HCPCS code for a 7.5-milligram injection of leuprolide acetate suspension, the procedure actually performed.[6] As a result of these errors, Palmetto paid the provider $125,467 when it should have paid $15,491, an overpayment of $109,976.

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

Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 65 line items. These errors resulted in overpayments totaling $460,290. The following examples illustrate the combination of incorrect units of service and incorrect HCPCS codes:

- One provider incorrectly billed Medicare for 1,400 units of immune globulin powder injection when it should have billed 70 units of Gamunex injection.[7] As a result, Palmetto paid the provider $37,361 when it should have paid $1,824, an overpayment of $35,537.

- Another provider incorrectly billed Medicare for 120 units of service for hemodialysis evaluation when it should have billed for 1 unit of service. For the same line item, this provider also used an incorrect HCPCS code for arteriovenous anastomosis.[8] As a result of these errors, Palmetto paid the provider $37,617 when it should have paid $1,681, an overpayment of $35,936.

Unallowable Services

Providers incorrectly billed Medicare for 18 line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling $96,314. For example, one provider billed Medicare for one line item that was unrelated to outpatient services.

[6] Leuprolide acetate can be used to treat prostate cancer, endometriosis, central precocious puberty, or other female hormone-related problems.

[7] Gamunex is a brand name of immune globulin, which provides antibodies to help prevent infection in certain patients who have weakened immune systems.

[8] Hemodialysis is a treatment for renal failure, and arteriovenous anastomosis is a surgical procedure to connect an artery and a vein.

Specifically, the provider incorrectly billed for a dental procedure (the removal of residual tooth roots) that is not covered by Medicare according to the *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 150. As a result of this error, Palmetto paid the provider $2,292 when it should have paid $0, an overpayment of $2,292.

Unsupported Services

Five providers billed Medicare for 19 line items for which the providers did not provide supporting documentation. The providers agreed to cancel the line items and refund the combined $68,571 overpayments that they received.

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. Palmetto 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.[9]

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

RECOMMENDATIONS

We recommend that Palmetto:

- recover the $7,545,772 in identified overpayments,
- 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.

[9] 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.

PALMETTO GBA, LLC, COMMENTS

In written comments on our draft report, Palmetto provided information on actions that it had taken or planned to take to address the recommendations. Palmetto's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: PALMETTO GBA, LLC, COMMENTS

Palmetto GBA
PARTNERS IN EXCELLENCE

Bruce W. Hughes
President and Chief Operating Officer

February 23, 2011

Lori A. Ahlstrand
Office of Inspector General
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
San Francisco, CA 94103

Reference: Report No. A-09-10-02018

Dear Ms. Ahlstrand:

This letter is in response to the recent Office of Inspector General (OIG) report entitled "*Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Palmetto GBA, LLC, in Jurisdiction 1 for the Period January1, 2006 Through June 30, 2009*", addressed to Mike Barlow. We appreciate the feedback that your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

As stated in the report, in September 2008 Palmetto GBA, LLC (Palmetto) assumed full responsibility as the Medicare administrative contractor for Jurisdiction 1 in three States and three territories. During the audit period approximately 187 million line items for outpatient services were processed, of which, 1,323 line items had

(1) a Medicare line payment amount that exceeded the line billed charge amount by at least $1,000

(2) a unit of service greater than 2 (The terms "line payment amount" and "line billed charges" signify that a single Medicare claim from a provider typically included more than one line item. For this audit items were reviewed for those line items that met the stated parameters.

Of the 1,323 selected line items for which Medicare payments to providers for outpatient services during the audit period, 397 were correct. The remaining 926 line items were incorrect. Thus the following recommendations:

- **Recover the $7,545,772 identified overpayments.**

  Palmetto GBA Response:
  All claims identified in the audit are adjusted and completed as of January 31, 2011.

- **Implement system edits that review line item payments that exceed billed charges by a prescribed amount.**

Palmetto GBA Response:
Palmetto GBA has implemented Medically Unlikely Edits (MUEs), Maximum Allowed Units (MAUs), and exclusion edits (e.g. dental, cosmetic).

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

Palmetto GBA Response:

A. Providers reported incorrect units of service on 638 line items, resulting in overpayments totaling $6,211,316.
   - Drugs and Biologicals were discussed on the, Ask the Contractor Teleconference (ACT) on November 18, 2010, specifically discussed billing the correct units of service, MAUs and MUEs.
   - Part A Outpatient PPS Billing presented at MACtoberfest held October 27 and October 28, 2010.
   - National Correct Coding Initiative (NCCI) Webinar was conducted on December 15, 2010; MUEs were discussed as well as the Outpatient Code Editor.

B. Providers used HCPCS codes that did not reflect the procedures performed for 186 line items, resulting in overpayments totaling $709,281.
   - Correct coding has been and continues to be discussed in each educational session.
   - Drugs and Biologicals Webinar instructed providers to identify drugs and biologicals with appropriate HCPCS code.

C. Providers reported a combination of incorrect units of service and incorrect HCPCS codes for 65 line items, resulting in overpayments totaling $460,290.
   - In the Drugs and Biologicals Webinar providers were instructed to identify drugs and biologicals with appropriate HCPCS code and the appropriate units.

D. Providers billed for unallowable services on 18 line items, resulting in overpayments totaling $96,314.
   - An ACT event was conducted for ABN & HINN on December 30, 2010, where we specifically discussed the proper way to report unallowable and non-covered services to Medicare.
   - The billing for unallowable services was also discussed in educational events focusing on claims payment error rate and Top 10 claim submission errors.

E. Providers could not provide supporting documentation for 19 line items, resulting in overpayments totaling $68,571.
   - On April 21, 2011, we plan to host a claims payment error rate documentation ACT event for Part A providers.
   - Proper documentation of services was covered at MACtoberfest on October 27 and 28, 2010.

- Our recent Claims Payment Error Rate/Claim Submission Errors One-on-One sessions focused on documentation and improper payments.
- The Top 10 Claim Submission Errors was discussed at MACtoberfest and several times in ACTs throughout the 2010 year.

Our Spring Provider Outreach and Education (POE) Tour for 2011 will focus on our largest specialties (Inpatient Hospitals and Skilled Nursing Facilities) which historically contribute to the top errors. Our POE Spring Tour for 2010 focused on the following:

- Provider Inquiry
- Claim Submission Errors
- Medical Review
- Comprehensive Error Rate Testing
- Recovery Audit Contractor

Additional upcoming provider outreach and education events include:

Claims Submission Errors	February 17, 2011
Billing and Coding	February 28, 2011; March 1, 2011

In addition, Palmetto GBA will address claims submission errors on a quarterly basis in our ACTs and monthly meetings with hospital Compliance Officers to increase awareness.

Thank you for providing Palmetto GBA with the opportunity to provide feedback regarding your review. If you have any questions, please do not hesitate to contact me.

Sincerely

Bruce W. Hughes

cc: Steven Smetak, COTR, CMS
Daniel Dion, CMS
Ann Archibald, Palmetto GBA
Mike Barlow, Palmetto GBA
Sheri Thompson, Palmetto GBA