

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW OF
CENTRO CARDIOVASCULAR
DE PUERTO RICO Y DEL CARIBE
FOR THE PERIOD JANUARY 1, 2008,
THROUGH JUNE 30, 2010**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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Brian P. Ritchie
Assistant Inspector General

September 2012
A-02-11-01023

Office of Inspector General

<http://oig.hhs.gov>

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EXECUTIVE SUMMARY

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and the State Children's Health Insurance Program Balanced Budget Refinement Act of 1999, P.L. No. 106-113. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification.

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Centro Cardiovascular de Puerto Rico y del Caribe (Cardiovascular) is a 192-bed hospital located in San Juan, Puerto Rico. Based on CMS's National Claims History data, Medicare paid Cardiovascular approximately \$27 million for 2,029 inpatient and 7,125 outpatient claims for services provided to Medicare beneficiaries for the period January 1, 2008, through June 30, 2010.

Our audit covered \$2,763,915 in Medicare payments to Cardiovascular for 41 inpatient and 130 outpatient claims that we judgmentally selected as potentially at risk for billing errors. These 171 claims had dates of service from January 1, 2008, through June 30, 2010.

OBJECTIVE

Our objective was to determine whether Cardiovascular complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

SUMMARY OF FINDINGS

Cardiovascular complied with Medicare requirements for billing inpatient and outpatient services for 157 of the 171 claims we reviewed. However, Cardiovascular did not fully comply with Medicare billing requirements for the remaining 14 claims, resulting in overpayments totaling \$72,139 for the period January 1, 2008 through June 30, 2010. Specifically, 3 inpatient claims had billing errors resulting in overpayments of \$33,085, and 11 outpatient claims had billing errors resulting in overpayments of \$39,054. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

RECOMMENDATIONS

We recommend that Cardiovascular,

- refund to the Medicare contractor overpayments of \$72,139 and
- strengthen controls to ensure full compliance with Medicare requirements.

CARDIOVASCULAR COMMENTS

In written comments on our draft report, Cardiovascular generally agreed with our first recommendation and described actions that it has taken or planned to take to address our second recommendation. Cardiovascular's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Title XVIII of the Social Security Act (the Act) established the Medicare program, which provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. Medicare Part A provides inpatient hospital insurance benefits and coverage of extended care services for patients after hospital discharge. Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of hospital outpatient services.

CMS contracts with Medicare contractors to, among other things, process and pay claims submitted by hospitals.¹

Hospital Inpatient Prospective Payment System

Section 1886(d) of the Act established the inpatient prospective payment system (IPPS) for hospital inpatient services. Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. The rates vary according to the diagnosis-related group (DRG) to which a beneficiary's stay is assigned. The DRG payment is, with certain exceptions, payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Hospital Outpatient Prospective Payment System

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services, as mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, and the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113.² The OPPS is effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification (APC). CMS uses Healthcare Common Procedure Coding System (HCPCS) codes and descriptors to identify and group the services within each APC group.³ All services and items within an APC group are comparable clinically and require comparable resources.

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 to 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. For purposes of this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC whichever is applicable.

² In 2009 SCHIP was formally redesignated as the Children's Health Insurance Program.

³ HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Hospital Payments at Risk for Incorrect Billing

Prior Office of Inspector General (OIG) audits, investigations, and inspections identified certain payments to hospitals that are at risk for noncompliance with Medicare billing requirements. OIG identified these types of payments to hospitals using computer matching, data mining, and analysis techniques. The types of payments included payments for claims billed for:

- inpatient same-day discharges and readmissions,
- inpatient claims billed with high severity level DRG codes,
- inpatient claims paid in excess of charges,
- inpatient and outpatient manufacturer credits for replaced medical devices,
- outpatient claims billed with modifier -59,
- outpatient claims billed during inpatient stays,
- outpatient evaluation and management services billed with surgical services, and
- outpatient claims paid in excess of charges.

For the purposes of this report, we refer to these areas at risk for incorrect billing as “risk areas.”

This review is part of a series of OIG reviews of Medicare payments to hospitals for selected claims for inpatient and outpatient services.

Medicare Requirements for Hospital Claims and Payments

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made for items and 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 precludes payment to any provider of services or other person without information necessary to determine the amount due to the provider.

Federal regulations (42 CFR § 424.5(a)(6)) state that the provider must furnish the Medicare contractor with sufficient information to determine whether payment is due and the amount of the payment.

The *Medicare Claims Processing Manual* (the Manual), Pub. No. 100-04, chapter 1, section 80.3.2.2, requires providers to complete claims accurately so that Medicare contractors may process them correctly and promptly. Chapter 23, section 20.3, of the Manual states that providers must use HCPCS codes for most outpatient services.

Centro Cardiovascular de Puerto Rico y del Caribe

Centro Cardiovascular de Puerto Rico y del Caribe (Cardiovascular) is a 192-bed hospital located in San Juan, Puerto Rico. Medicare paid Cardiovascular approximately \$27 million for 2,029 inpatient and 7,125 outpatient claims for services provided to Medicare beneficiaries for the period January 1, 2008, through June 30, 2010, based on CMS's National Claims History data.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Cardiovascular complied with Medicare requirements for billing inpatient and outpatient services on selected claims.

Scope

Our audit covered \$2,763,915 in Medicare payments to Cardiovascular for 171 claims that we judgmentally selected as potentially at risk for billing errors. These 171 claims had dates of service from January 1, 2008, through June 30, 2010, and consisted of 41 inpatient and 130 outpatient claims.

We focused our review on the risk areas that we had identified during and as a result of prior OIG reviews at other hospitals. We evaluated compliance with selected billing requirements but did not use medical review to determine whether the services were medically necessary.

We limited our review of Cardiovascular's internal controls to those applicable to the inpatient and outpatient areas of review because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review enabled us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the CMS's National Claims History file, but we did not assess the completeness of the file.

This report focuses on selected risk areas and does not represent an overall assessment of all claims submitted by Cardiovascular for Medicare reimbursement.

We conducted our fieldwork at Cardiovascular in San Juan, Puerto Rico.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Cardiovascular's inpatient and outpatient paid claim data from CMS's National Claims History file for the period January 1, 2008, through June 30, 2010;

- obtained information on known credits for replacement cardiac medical devices from the device manufacturers for the period January 1, 2008, through June 30, 2010;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a judgmental sample of 171 claims (41 inpatient and 130 services) for detailed review;
- reviewed available data from CMS's Common Working File for selected sampled claims to determine whether the claims had been cancelled or adjusted;
- reviewed the itemized bills and medical record documentation provided by Cardiovascular to support the sampled claims;
- requested that Cardiovascular conduct its own review of the sampled claims to determine whether the services were billed correctly;
- reviewed Cardiovascular's procedures for assigning HCPCS codes and submitting Medicare claims;
- discussed the incorrectly billed claims with hospital personnel to determine the underlying causes of noncompliance with Medicare requirements;
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our review with Cardiovascular officials.

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

Cardiovascular complied with Medicare requirements for billing inpatient and outpatient services for 157 of the 171 claims we reviewed. However, Cardiovascular did not fully comply with Medicare billing requirements for the remaining 14 claims, resulting in overpayments totaling \$72,139 for the period January 1, 2008, through June 30, 2010. Specifically, 3 inpatient claims had billing errors resulting in overpayments totaling \$33,085, and 11 outpatient claims had billing errors resulting in overpayments totaling \$39,054. These overpayments occurred primarily because the Hospital did not have adequate controls to prevent incorrect billing of Medicare claims.

Only risk areas with errors are listed in the findings and recommendations below.

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

Cardiovascular incorrectly billed Medicare for 3 of the 41 inpatient claims that we reviewed. These errors resulted in overpayments totaling \$33,085.

Inpatient Claims Paid in Excess of Charges

Section 1862(a)(1)(A) of the Act states that Medicare payments may not be made 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.” Additionally, the Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

For 2 of the 25 sampled claims, Cardiovascular incorrectly billed Medicare Part A for inpatient stays that should have been billed as outpatient or outpatient with observation services. Cardiovascular attributed this to human error. As a result, Cardiovascular received overpayments totaling \$11,085.

Inpatient Manufacturer Credits for Replacement of Medical Devices

Federal regulations (42 CFR § 412.89) require reductions in the IPPS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider, (2) the provider receives full credit for the cost of a device, or (3) the provider receives a credit equal to 50 percent or more of the cost of the device. The Manual, chapter 3, section 100.8, states that to bill correctly for a replacement device that was provided with a credit, the hospital must use the combination of condition code “49” or “50” along with value code “FD.”

For 1 of the 12 sampled claims, Cardiovascular received full credit from the manufacturer for a replaced medical device but did not adjust its inpatient claim with the proper value and condition code. This error occurred because Cardiovascular did not have adequate controls to properly report credits from device manufacturers. As a result, Cardiovascular received an overpayment of \$22,000.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Cardiovascular incorrectly billed Medicare for 11 of the 130 outpatient claims that we reviewed. These errors resulted in overpayments totaling \$39,054.

Outpatient Claims Billed With Modifier -59

The Manual, chapter 1, section 80.3.2.2, states: “In order to be processed correctly and promptly, a bill must be completed accurately.” In addition, chapter 23, section 20.9.1.1, states: “The ‘-59’ modifier is used to indicate a distinct procedural service This may represent a different session or patient encounter, different procedure or surgery, different site, or organ system, separate incision/excision, or separate injury (or area of injury in extensive injuries).”

For 8 of the 119 sampled claims, Cardiovascular incorrectly billed Medicare for HCPCS codes that did not require modifier -59 (4 errors), or were included in payments for other services billed on the same claim (4 errors). Cardiovascular stated that these errors occurred primarily because of human error, including staff misunderstanding of billing requirements for modifier -59. As a result, Cardiovascular received overpayments totaling \$20,039.

Outpatient Manufacturer Credits for Replacement of Medical Devices

Federal regulations (42 CFR § 419.45) require a reduction in the OPSS payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credit equal to or greater than 50 percent of the cost of the replacement device.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and the Manual, chapter 4, section 61.3, explain how a provider should report no-cost and reduced-cost devices under the OPSS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier “FB” and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

Prudent Buyer Principle

Federal regulations (42 CFR § 413.9) state: “All payments to providers of services must be based on the reasonable cost of services” The *CMS Provider Reimbursement Manual* (PRM), part I, section 2102.1, states: “Implicit in the intention that actual costs be paid to the extent they are reasonable is the expectation that the provider seeks to minimize its costs and that its actual costs do not exceed what a prudent and cost conscious buyer pays for a given item or service. If costs are determined to exceed the level that such buyers incur, in the absence of clear evidence that the higher costs were unavoidable, the excess costs are not reimbursable under the program.

Section 2103 of the PRM further defines prudent buyer principles and states that Medicare providers are expected to pursue free replacements or reduced charges under warranties. Section 2103(C)(4) of the PRM provides the following example:

Provider B purchases cardiac pacemakers or their components for use in replacing malfunctioning or obsolete equipment, without asking the supplier/manufacturer for full or partial credits available under the terms of the warranty covering the replaced equipment. The credits or payments that could have been obtained must be reflected as a reduction of the cost of the equipment.

For 3 of the 9 sampled claims, Cardiovascular did not obtain credits for replaced medical devices that were available under the terms of the manufacturers' warranties. This occurred because Cardiovascular did not have controls to identify, obtain, and report credits from the device manufacturers. As a result, Cardiovascular received overpayments totaling \$19,015.

RECOMMENDATIONS

We recommend that Cardiovascular:

- refund to the Medicare contractor overpayments of \$72,139 and
- strengthen controls to ensure full compliance with Medicare requirements.

CARDIOVASCULAR COMMENTS

In written comments on our draft report, Cardiovascular generally agreed with our first recommendation and described actions that it has taken or planned to take to address our second recommendation.

Cardiovascular disagreed with our findings related to manufacturer credits for the replacement of medical devices. Regarding Cardiovascular's receipt of a \$22,000 credit related to an inpatient claim for which Cardiovascular did not adjust the claim, Cardiovascular indicated that, once the device's manufacturer and our office made the hospital aware of the fact that the device qualified for a credit, Cardiovascular adjusted the claim and refunded the overpayment. Regarding three outpatient claims for which Cardiovascular did not obtain manufacturers' credits for replaced medical devices, Cardiovascular stated that it has not received a reimbursement check or credit memo from the associated manufacturer. However, Cardiovascular agreed to refund the overpayments and initiate procedures to address our findings. Cardiovascular's comments are included in their entirety as the Appendix.

APPENDIX



Centro Cardiovascular
de Puerto Rico y del Caribe
Dr. Ramón M. Suárez Calderón
Estado Libre Asociado de Puerto Rico
AL RITMO DE TU CORAZON

August 3, 2012

Report Number: A-02-11-01023

Mr. James P. Edert
Regional Inspector General
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Dear Mr. Edert:

The Cardiovascular Center of Puerto Rico and the Caribbean acknowledges the receipt, and has reviewed the findings of the U.S. Department of Health and Human Services, Office of Inspector General (OIG), draft report entitled Medicare Compliance of Centro Cardiovascular de Puerto Rico y del Caribe for the Period January 1, 2008, through June 30, 2010. As requested by your office, the Cardiovascular Center has reviewed your recommendations and has included a statement for each occurrence below:

BILLING ERRORS ASSOCIATED WITH INPATIENT CLAIMS

The Cardiovascular incorrectly billed Medicare for 3 of the 41 inpatient claims that we reviewed. These errors resulted in overpayments totaling \$33,085.

INPATIENT CLAIMS PAID IN EXCESS OF CHARGES

For 2 of the 25 sampled claims, Cardiovascular incorrectly billed Medicare Part A for inpatient stays that should have been billed as outpatient or outpatient with observation services. Cardiovascular attributed this to human error. As a result, Cardiovascular received overpayment totaling \$11,085.

The Cardiovascular Center of Puerto Rico and the Caribbean agrees with your findings. In order to prevent this to happen again, we have implemented the following actions:

1. Reinforce the correct use of the Admission Order to assure the correct documentation and the adequate level of service.
2. Maintain Adequate daily monitoring of the level of service (inpatient or ambulatory service with observation) by medical record coders and utilization program case managers, in order to assure the correct billing process.
3. Perform quality audits for unnecessary admissions.

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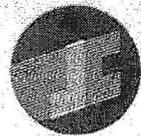
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Sector Público

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Inpatient Manufacturer Credits for Replacement of Medical Devices

For 1 of the 12 sampled claims, Cardiovascular received full credit from the manufacturer for a replaced medical device but did not adjust its inpatient claim with the proper value and condition code. This error occurred because Cardiovascular did not have adequate controls to properly report credits from device manufacturers. As a result, Cardiovascular received an overpayment of \$22,000.

The Cardiovascular Center of Puerto Rico and the Caribbean disagrees with your findings in this case, because during our review of this case on June 2011, we contacted the device manufacturer and weeks later we received a letter from them. This letter explained that they became aware that the device replaced on 2009 qualified for warranty credit during an audit from the Office of the Inspector General on their organization in a previous date but didn't inform the Cardiovascular Center until July 2011 after we contacted them in relation to this case. Invoices and credit memos were received on a letter dated July 27, 2011, from the auditing period of 2008-2010 that included this case. As we acknowledge this information, we informed the OIG auditor of this credit pending to be credited and asked him how to proceed since we were in the middle of the audit process, but didn't receive any answer regarding on how to proceed. We decided to resubmit the invoices to CMS with the corresponding warranty credit for the appropriate sum according to CMS reimbursement formula at the referred period. In addition to this, in order to avoid any delay on warranty credits claims to device manufacturer and submit proper billing to CMS, we developed a Rule and Procedure to address the correct pathways that will be followed prior to billing processing order to comply in each case with the proper reporting of credits from the manufacturers.

BILLING ERRORS ASSOCIATED WITH OUTPATIENT CLAIMS

Cardiovascular incorrectly billed Medicare for 11 of the 130 outpatient claims that we reviewed. These errors resulted in overpayments totaling \$39,054.

Outpatient Claims Billed With Modifier – 59

For 8 of the 119 sampled claims, Cardiovascular incorrectly billed Medicare for HCPCS codes that did not require modifier – 59. (4 errors), or were included in payments for other services billed on the same claim (4 errors). Cardiovascular stated that these errors occurred primarily because of human error, including staff misunderstanding of billing requirements for modifier – 59. As a result, Cardiovascular received overpayments totaling \$20,039.

The Cardiovascular Center of Puerto Rico and the Caribbean agrees with your findings. In order to prevent this to happen again, we have developed the following strategies:

- The Medical Record Department has implemented an advanced training program in the use of modifier 59 for outpatient coding.

- The Cardiovascular Center of Puerto Rico and the Caribbean will continue to monitor all of the audited areas and will be updating its internal procedures as necessary.
The Cardiovascular Center of Puerto Rico and the Caribbean will conduct a special coding and compliance education, monitoring and auditing.
- To strengthen controls to ensure full compliance with Medicare requirements, we have implemented several measures, including the following:
 1. Modified edits in the billing system for cases with modifier 59.
 2. Assign corrected CPT codes in areas where errors occurred.
 3. Most importantly, both the physician and hospital staff should ensure that everyone associated with the coding and billing process understand the implications of reporting modifier 59 inappropriately.

Outpatient Manufacturer Credits for Replacement of Medical Devices

Federal regulations (42 CFR & 419.45) required a reduction in the outpatient prospective payment system payment for the replacement of an implanted device if (1) the device is replaced without cost to the provider or the beneficiary, (2) the provider receives full credit for the cost of the replaced device, or (3) the provider receives partial credits equal to or greater than percent of the cost of the replacement device.

The Cardiovascular Center of Puerto Rico and the Caribbean agrees with your findings, and has developed a Rule and Procedure to address the correct pathways to follow prior to billing, in order to comply in each case with the properly report credits from the manufacturers.

Billing Requirements for Medical Device Credits

CMS guidance in Transmittal 1103, dated November 3, 2006, and its Medicare Claims Processing Manual (the Manual) explain how a provider should report no-cost and reduced-cost devices under the OPPS. For services furnished on or after January 1, 2007, CMS requires the provider to report the modifier "FB" and reduced charges on a claim that includes a procedure code for the insertion of a replacement device if the provider incurs no cost or receives full credit for the replaced device.

The Cardiovascular Center of Puerto Rico and the Caribbean agrees with your findings, and has developed a Rule and Procedure to address the correct pathways to follow prior to billing, in order to comply in each case with the properly report credits from the manufacturers.

Prudent Buyer Principle

For 3 of the 9 sampled claims, Cardiovascular did not obtain credits for replaced medical devices that were available under the terms of the manufacturers'

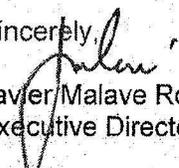
warranties. This occurred because Cardiovascular did not have controls to identify, obtain, and report credits from the device manufacturers. As a result, Cardiovascular received overpayments totaling \$19,015.

The Cardiovascular Center of Puerto Rico and the Caribbean disagrees with your findings in this case. As of today, we do not have any reimbursement check nor credit memo from the manufacturer on behalf of the overpayments totaling \$19,015, as you stated above. As an internal control measure, the Cardiovascular Center of Puerto Rico and the Caribbean has developed a Rule and Procedure to address the correct pathways to follow prior to billing, in order to comply in each case with the properly report credits from the manufacturer.

Although we disagree in part, with your findings in this audit; as you recommended we paid the sum of \$72,139.00, in two payments: a voluntary refund check of \$10,485.00, issued and delivered to CMS on October 2011, and the remaining balance of \$61,654.00, issued and delivered to CMS once we acknowledged the receipt of the (OIG) draft report.

We would like to thank you for your support and collaboration during the audit review. If you have any questions, please feel free to contact me at (787) 754-8500 ext. 3004, 3005.

Sincerely,


Javier Malave Rosario, MHSA, CHE
Executive Director

WRP/jmr