July 1, 2010

Report Number: A-05-09-00077

Ms. Sherrie LeMier
President and Chief Operating Officer
Cahaba Government Benefit Administrators, LLC
300 Corporate Parkway
Birmingham, AL 35242

Dear Ms. LeMier:

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

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.


If you have any questions or comments about this report, please do not hesitate to call me, or contact David Markulin, Audit Manager, at (312) 353-1644 or through email at David.Markulin@oig.hhs.gov. Please refer to report number A-05-09-00077 in all correspondence.

Sincerely,

/James C. Cox/
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 and Medicaid Services
601 East 12th Street, Room 235
Kansas City, MO 64106
Department of Health & Human Services
OFFICE OF INSPECTOR GENERAL

REVIEW OF CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, MEDICARE PAYMENTS TO PROVIDERS TERMINATED BETWEEN JANUARY 1, 2003, AND JANUARY 31, 2007

Daniel R. Levinson
Inspector General
July 2010
A-05-09-00077
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 & 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 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, uses Medicare contractors, such as fiscal intermediaries (FI), to process and pay Medicare claims submitted by health care providers. Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act to require that Medicare administrative contractors (MAC) replace FIs and carriers by October 2011.

Medicare contractors, such as FIs and MACs, must comply with Medicare laws, regulations, and guidance, including provisions for processing payments to terminated Medicare providers. Section 1866(b) of the Act provides for the termination of provider agreements, which set forth the terms and conditions for participation in the Medicare program. Sections 1814(a) and 1866 of the Act generally do not allow payment for services provided on or after an agreement’s termination date. The Medicare Financial Management Manual, Pub. No. 100-06, chapter 7, requires Medicare contractors to maintain internal controls to prevent erroneous payments; chapter 3 requires Medicare contractors to pursue recovery of overpayments, including those made to terminated Medicare providers.

Cahaba Government Benefit Administrators, LLC (Cahaba), was an FI during our audit period (January 1, 2003, through January 31, 2007). CMS subsequently awarded a MAC contract to Cahaba for the administration of Medicare Part A and Part B claims.

OBJECTIVE

Our objective was to determine whether Cahaba recovered Medicare overpayments for services furnished on or after the effective termination dates of provider agreements.

SUMMARY OF FINDING

We did not identify material Cahaba overpayments that were subject to recovery as of the start of our audit for 388 of the 389 terminated providers whose payments we reviewed. However, for the one remaining provider, Cahaba did not recover $5,355 in overpayments because it was unaware that the payments were unallowable. Cahaba confirmed that the overpayments were subject to recovery.

RECOMMENDATION

We recommend that Cahaba recover $5,355 in overpayments to one terminated provider.
CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

In written comments to our draft report, Cahaba stated that it agreed with our recommendation and has recovered the overpayments. Cahaba’s comments are included in their entirety as the Appendix.
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INTRODUCTION

BACKGROUND

Medicare Program

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people 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, uses Medicare contractors, such as fiscal intermediaries (FI), to process and pay Medicare claims submitted by health care providers. Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act to require that Medicare administrative contractors (MAC) replace FIs and carriers by October 2011.

Medicare Payment Requirements

Medicare contractors, such as FIs and MACs, must comply with Medicare laws, regulations, and guidance, including provisions for processing payments to terminated Medicare providers. Section 1866(b) of the Act provides for the termination of provider agreements, which set forth the terms and conditions for participation in the Medicare program. Sections 1814(a) and 1866 of the Act generally do not allow payment for services provided on or after an agreement’s termination date. The Medicare Financial Management Manual, Pub. No. 100-06, chapter 7, requires Medicare contractors to maintain internal controls to prevent erroneous payments; chapter 3 requires Medicare contractors to pursue recovery of overpayments, including those made to terminated Medicare providers.

Cahaba Government Benefit Administrators, LLC

Cahaba Government Benefit Administrators, LLC (Cahaba), was an FI during our audit period (January 1, 2003, through January 31, 2007). CMS subsequently awarded a MAC contract to Cahaba for the administration of Medicare Part A and Part B claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Cahaba recovered Medicare overpayments for services furnished on or after the effective termination dates of provider agreements.

Scope

We reviewed Cahaba payments to 389 providers with effective termination dates between January 1, 2003, and January 31, 2007. The reviewed payments were for services furnished on or after the providers’ effective termination dates. We limited our review of internal controls to
discussing with Cahaba officials the procedures used to retroactively identify and recover the 
overpayments identified during our review.

Our fieldwork included contacting Cahaba in Birmingham, Alabama.

Methodology

To accomplish our objective, we:

- used a CMS nationwide list of providers with effective termination dates during the audit 
  period to query the National Claims History files;

- identified 389 Cahaba-serviced providers that received Medicare payments for services 
  furnished during or after our audit period;

- analyzed CMS, National Claims History, and Cahaba data and identified one provider that 
  received $5,000 or more in overpayments for services furnished on or after the provider’s 
  effective termination date; and

- worked with Cahaba to quantify the overpayments that were subject to recovery as of the 
  start of our audit.

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

FINDING AND RECOMMENDATION

We did not identify material Cahaba overpayments that were subject to recovery as of the start of 
our audit for 388 of the 389 terminated providers whose payments we reviewed. However, for 
the one remaining provider, Cahaba did not recover $5,355 in overpayments because it was 
unaware that the payments were unallowable. Cahaba confirmed that the overpayments were 
subject to recovery.

FEDERAL REQUIREMENTS

Section 1814(a) of the Act provides that “payment for services furnished an individual may be 
made only to providers of services which are eligible therefor under section 1866 [which sets 
forth the requirements for provider agreements] ….” Pursuant to section 1866(b)(2) of the Act 
and 42 CFR §§ 489.53 and 489.54, CMS or the Office of Inspector General may terminate a 
provider agreement for cause. Additionally, section 1866(b)(1) of the Act and 42 CFR § 489.52 
permit a Medicare provider to voluntarily terminate its provider agreement. Except in certain 
limited circumstances considered during this audit, such as those described in 42 CFR § 489.55,
no Medicare payment is available for services furnished to a beneficiary on or after the effective
date of termination of a provider agreement.

contractors to maintain internal controls to prevent and detect erroneous payments; chapter 3
requires Medicare contractors to pursue recovery of overpayments.

OVERPAYMENTS NOT RECOVERED

As of the start of our audit, Cahaba had not recovered $5,355 in Medicare overpayments to one
provider for services furnished on or after the provider’s effective termination date. Cahaba
officials indicated that the overpayments were not recovered because the CMS claims payment
system and Cahaba personnel did not recognize the payments as unallowable. By December
2008, updates had been made to prevent future unallowable payments of the type that were
identified for this provider. Cahaba confirmed that the overpayments were subject to recovery.

RECOMMENDATION

We recommend that Cahaba recover $5,355 in overpayments to one terminated provider.

CAHABA GOVERNMENT BENEFIT ADMINISTRATORS, LLC, COMMENTS

In written comments to our draft report, Cahaba stated that it agreed with our recommendation
and has recovered the overpayments. Cahaba’s comments are included in their entirety as the
Appendix.
APPENDIX
June 11, 2010

Department of Health and Human Services
Office of Inspector General
Office of Audit Services, Region V
Attention: James C. Cox
Regional Inspector General for Audit Services
233 North Michigan Avenue
Suite 1360
Chicago, IL 60601


Dear Mr. Cox,

We are in receipt of the captioned draft report. We agree with the report and recommendations. We issued a demand letter for $5,355.12 to the provider noted in the report for the 318 unallowable post-termination claims and received a check from the provider for the full amount on July 14, 2009.

If you should have any questions regarding this report, please contact Molly Echols, Manager Risk and Compliance at (205) 220-1587 or via email at Mechols@cahabagba.com.

Sincerely,

Sherrie D. LeMier

CC: Brandon Ward, Vice President, Cahaba GBA Operations
    David Brown, Director, Cahaba GBA Administration
    Jim Hill, A/B Claims Operation Divisional Manager
    Fred Schlich, Manager of Cahaba GBA Contracts/Subcontracts

500 Corporate Parkway • Birmingham, Alabama 35242-3425
A UMS Medicare Administrative Contractor