



Office of Audit Services, Region III
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Philadelphia, PA 19106-3499

November 30, 2011

Report Number: A-03-11-00005

Mr. Bruce Hughes
President and Chief Operating Officer
Palmetto GBA, LLC
P.O. Box 100134
Columbia, SC 29202

Dear Mr. Hughes:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges by \$500 to \$1,000 for Outpatient Services Processed by National Government Services but Transitioned to Palmetto GBA, LLC, in Jurisdiction 11 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 call me at (215) 861-4470, or contact Bernard Siegel, Audit Manager, at (215) 861-4484 or through email at Bernard.Siegel@oig.hhs.gov. Please refer to report number A-03-11-00005 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

cc:

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Vice President

J11 AB MAC Operations

Ms. Yvonna Ruff

Director

Part A Claims

National Government Services Medicare

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Consortium for Financial Management & Fee for Service Operations

Centers for Medicare & Medicaid Services

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Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
EXCEEDING CHARGES
BY \$500 TO \$1,000 FOR
OUTPATIENT SERVICES PROCESSED BY
NATIONAL GOVERNMENT SERVICES
BUT TRANSITIONED TO
PALMETTO GBA, LLC,
IN JURISDICTION 11
FOR THE PERIOD JANUARY 1, 2006,
THROUGH JUNE 30, 2009**



Daniel R. Levinson
Inspector General

November 2011
A-03-11-00005

Office of Inspector General

<http://oig.hhs.gov>

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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 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 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.

Before May 16, 2011, National Government Services (NGS) was the Medicare fiscal intermediary for Virginia and West Virginia. From January 2006 through June 2009, NGS processed approximately 92 million line items for outpatient services, of which 925 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by \$500 to \$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.") We reviewed only 915 of these line items because 1 provider associated with 10 line items was no longer in business.

On May 21, 2010, CMS announced that Palmetto GBA, LLC (Palmetto), had been awarded the contract as the Medicare administrative contractor for Jurisdiction 11 in four States: North Carolina, South Carolina, Virginia, and West Virginia. For Virginia and West Virginia providers, the effective date for transferring from NGS to Palmetto was May 16, 2011. Because Palmetto has assumed responsibility for claims paid by NGS, we have addressed our findings and recommendations to Palmetto for review and comment.

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges by \$500 to \$1,000 that NGS made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 915 selected line items for which NGS made Medicare payments to providers for outpatient services during our audit period, 231 were correct. Providers refunded overpayments on 193 line items totaling \$124,807 before our fieldwork. The remaining 491 line items were incorrect and included overpayments totaling \$446,581 that the providers had not refunded by the beginning of our audit.

Of the 491 incorrect line items:

- Providers reported incorrect units of service on 255 line items, resulting in overpayments totaling \$230,028.
- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 151 line items, resulting in overpayments totaling \$124,619.
- Providers did not provide supporting documentation for 57 line items, resulting in overpayments totaling \$67,446.
- Providers billed separately for services on 11 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling \$10,104.
- Providers billed for unallowable services or drugs on eight line items, resulting in overpayments totaling \$8,925.
- Providers used incorrect HCPCS codes on nine line items, resulting in overpayments totaling \$5,459.

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. NGS 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 \$446,581 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 generally concurred with our findings and recommendations and described corrective actions that it had taken or planned to take. 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. 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. 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 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 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.

National Government Services and Palmetto GBA, LLC

Before May 16, 2011, National Government Services (NGS) was the Medicare fiscal intermediary for Virginia and West Virginia. From January 2006 through June 2009, NGS processed approximately 92 million line items for outpatient services.

On May 21, 2010, CMS announced that Palmetto GBA, LLC (Palmetto), had been awarded the contract as the MAC for Jurisdiction 11 in four States: North Carolina, South Carolina, Virginia, and West Virginia. For Virginia and West Virginia providers, the effective date for transferring from NGS to Palmetto was May 16, 2011. Because Palmetto has assumed responsibility for claims paid by NGS, we have addressed our findings and recommendations to Palmetto for review and comment.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges by \$500 to \$1,000 that NGS made to providers for outpatient services were correct.

Scope

Of the approximately 92 million line items for outpatient services that NGS processed during the period January 2006 through June 2009, 925 line items totaling \$1,100,492 had (1) a Medicare line payment amount that exceeded the line billed charge amount by \$500 to \$1,000 and (2) 3 or more units of service.³ We reviewed only 915 of these line items because one provider associated with 10 line items was no longer in business.

We limited our review of NGS'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.

This report includes all items with payments for line items that exceeded the billed charges by \$500 to \$1,000. We will report the results of our review of all items with payments for line items that exceeded billed charges by at least \$1,000 separately in report number A-03-10-00005.

Our fieldwork included contacting NGS in Indianapolis, Indiana, and the 56 providers in Virginia and West Virginia that received the selected Medicare payments.

³ 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."

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 in which (1) Medicare line payment amounts exceeded the line billed charge amounts by \$500 to \$1,000 and (2) the line item had 3 or more units of service;⁴
- identified 915 line items, totaling \$1,094,192, that Medicare paid to 56 providers;
- contacted the 56 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 NGS; and
- discussed the results of our review with NGS on May 12, 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 915 selected line items for which NGS made Medicare payments to providers for outpatient services during our audit period, 231 were correct. Providers refunded overpayments on 193 line items totaling \$124,807 before our fieldwork. The remaining 491 line items were incorrect and included overpayments totaling \$446,581 that the providers had not refunded by the beginning of our audit.

Of the 491 incorrect line items:

- Providers reported incorrect units of service on 255 line items, resulting in overpayments totaling \$230,028.
- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 151 line items, resulting in overpayments totaling \$124,619.

⁴ 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 payments and charges to less than \$500.

- Providers did not provide supporting documentation for 57 line items, resulting in overpayments totaling \$67,446.
- Providers billed separately for services on 11 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling \$10,104.
- Providers billed for unallowable services or drugs on eight line items, resulting in overpayments totaling \$8,925.
- Providers used incorrect HCPCS codes on nine line items, resulting in overpayments totaling \$5,459.

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. NGS 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.” 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 255 line items, resulting in overpayments totaling \$230,028. The following examples illustrate incorrect units of service claimed:

- Twenty-six providers billed Medicare for 76 line items with incorrect service units involving 35 different drugs, biologicals,⁵ and blood products. Rather than billing between 0 and 250 service units, providers billed between 3 and 750 service units. These errors occurred because of human error or because the provider's chargemaster⁶ was incorrect. As a result of these errors, NGS paid the 26 providers a total of \$114,482 when it should have paid \$24,658, an overpayment of \$89,824.
- Six providers billed Medicare for 31 line items with an incorrect number of blood products (HCPCS J0152). Rather than billing between 2 and 3 service units, providers billed between 14 and 30 service units. As a result of these errors, NGS paid the six providers \$31,310 when it should have paid \$4,866, an overpayment of \$26,444.
- Seven providers billed Medicare for 11 line items with an incorrect number of surgical procedures performed. Rather than billing for the number of surgical procedures performed, providers either billed the wrong number of procedures or billed for the units of time (e.g., minutes, quarter-hours, and hours) spent in the surgical suite. For each of the 11 cases, the providers performed between 1 and 7 surgical procedures but billed for between 3 and 61 services. As a result of these errors, NGS paid the 7 providers \$29,951 when it should have paid \$7,303, an overpayment of \$22,648.

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 and incorrect HCPCS codes on 151 line items. These errors resulted in overpayments totaling \$124,619. The following examples illustrate the combination of incorrect number of units of service claimed and incorrect HCPCS codes used:

- One provider billed Medicare for between 5 and 16 service units of Red blood cells, leukocytes reduced, irradiated (HCPCS code P9040). However, the provider should have billed between 1 and 7 units of Red blood cells, leukocytes reduced (HCPCS code P9016), the dose actually administered. Similar errors occurred on a total of 35 line items that this provider submitted. As a result of these errors, NGS paid the provider \$79,791 when it should have paid \$29,871, an overpayment of \$49,920.
- One provider billed Medicare for between 4 and 9 service units of Red blood cells, leukocytes reduced, irradiated (HCPCS code P9040). However, the provider should have billed between 1 and 4 service units of Red blood cells, leukocytes reduced, cmv-negative, irradiated (HCPCS code P9058), the dose actually administered. Similar errors occurred on a total of 57 line items that this provider submitted. As a result of these errors, NGS paid the provider \$65,625 when it should have paid \$22,645, an overpayment of \$42,980.

⁵ Biologicals are substances made from a living organism or its products that are used to prevent, diagnose, treat, or relieve symptoms of a disease.

⁶ A provider's chargemaster contains data on every chargeable item or procedure that the provider offers, including a factor that converts a drug's dosage to the number of units to bill.

Unsupported Services

Nine providers billed Medicare for 57 line items for which the providers did not provide supporting documentation. The providers agreed to cancel the claims associated with these line items or file adjusted claims and refund the combined \$67,446 overpayments that they received.

Payment for Packaged Services

Six providers billed Medicare on 11 line items for services that were not separately payable by Medicare. These services were billed as separately payable drugs rather than ordinary pharmacy drugs that are packaged in the payment for the primary procedure. These errors resulted in overpayments totaling \$10,104. For example, one provider billed Medicare for three line items for Paclitaxel protein bound (HCPCS code J9264). During the dates of service that the providers administered these drugs, Medicare included payment for these drugs in the payment for the primary procedure and did not provide for separate reimbursement under the prospective payment system. As a result of these errors, NGS incorrectly paid the provider \$2,095.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for eight line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling \$8,925. The following examples illustrate claimed services that were not allowable for Medicare reimbursement:

- Two providers billed Medicare for six line items for an evaluation and management code (office visit) rather than for a hospital observation code, the actual service provided. For these line items, the hospital observation services were not allowable for Medicare reimbursement. As a result of these errors, NGS overpaid the two providers \$5,634.
- One provider billed Medicare for one line item for one dental procedure that was not a covered outpatient service. According to the *Medicare Benefit Policy Manual* (Pub. No. 100-02, chapter 15, section 150), “items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered” by Medicare, unless the dental procedure is an integral part of another procedure covered by Medicare. The dental service billed was not an integral part of another covered procedure. As a result of this error, NGS overpaid the provider \$2,586.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used incorrect HCPCS codes for nine line items, resulting in overpayments totaling \$5,459. The following examples illustrate the use of incorrect HCPCS codes:

- One provider billed Medicare for 3 line items for 16 units of service of Pegademase bovine (HCPCS code J2504) rather than Ondansetron hydrochloride injection (HCPCS code J2405), the drug actually administered. As a result of this error, NGS paid the provider \$2,351 when it should have paid \$48, an overpayment of \$2,303.

- One provider billed Medicare for two line items for eight units of service of Platelets pheresis (HCPCS code P9034) rather than Platelets irradiated (HCPCS code P9032), the biological actually administered. As a result of this error, NGS paid the provider \$2,145 when it should have paid \$829, an overpayment of \$1,316.

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. NGS 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.⁷

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 \$446,581 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 generally concurred with our findings and recommendations and described corrective actions that it had taken or planned to take. Palmetto's comments are included in their entirety as the Appendix.

⁷ 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.

APPENDIX

APPENDIX: PALMETTO GBA, LLC, COMMENTS



Bruce W. Hughes
President and Chief Operating Officer

October 27, 2011

Stephen Virbitsky
Office of Inspector General
Office of Audit Services, Region III
Public Ledger Building, Suite 316
150 S. Independence Mall West
Philadelphia, PA 19106-3499

Reference: Draft Report No. A-03-11-00005

Dear Mr. Virbitsky:

This letter is in response to the recent Office of Inspector General (OIG) report entitled “*Review of Medicare Payments Exceeding Charges Between \$500 and \$1,000 for Outpatient Services Processed by National Government Services, in Jurisdiction 11 for the Period January 1, 2006 Through June 30, 2009*”, addressed to Bruce Hughes. We appreciate the feedback your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

As stated in the report, Palmetto GBA, LLC (Palmetto) assumed full responsibility as the Medicare Administrative Contractor (MAC) for Jurisdiction 11 effective June 2011. During the audit period approximately 915 line items were selected which had:

- (1) a Medicare line payment amount that exceeded the line billed charge between \$500 and \$1,000
- (2) incorrect units of service
- (3) a combination of incorrect units of service and incorrect HCPCS
- (4) no supporting documentation provided
- (5) separate billing for packaged services
- (6) billing for unallowable services
- (7) use of incorrect HCPCS codes

Of the 915 selected line items for which Medicare made payments to providers for outpatient services during the audit period, 231 were correct. Providers refunded overpayments on 193 line items totaling \$124,807 before fieldwork. The remaining 491 line items were incorrect. Thus the following recommendations:

- **Recover the \$446,581 identified overpayments.**

Palmetto GBA Response:

All claims identified in the audit are adjusted for payment recovery and completed as of October 24, 2011.

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

Stephen Virbitsky
 October 27, 2011
 Page 2

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:

- Correct coding has been and continues to be discussed in each educational session.
- Drugs and Biologicals Webinars instruct providers to identify drugs and biologicals with appropriate HCPCS codes.
- In the Drugs and Biologicals Webinar providers are instructed to identify drugs and biologicals with appropriate HCPCS codes and appropriate numbers of units.
- Billing for unallowable services is and will continue to be discussed in CERT education and Top 10 Claim Submission Errors educational presentations.
- Our recent CERT/Claim Submission Errors One-on-One sessions focused on documentation and improper payments.
- Additional 2011 and 2012 provider outreach and education events include seminars and workshops on:
 - Claims Submission Errors
 - Billing and Coding
 - Part B of A Small and New Provider Billing Training
 - CERT
 - Top Denials and Inquiries.

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

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.

Sincerely

/BRUCE HUGHES/

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