



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
OFFICE OF AUDIT SERVICES  
233 NORTH MICHIGAN AVENUE  
CHICAGO, ILLINOIS 60601

REGION V  
OFFICE OF  
INSPECTOR GENERAL

August 16, 2005

Report Number: A-05-05-00042

Mr. Robert Palmer  
President and CEO  
Dean Health Plan, Inc.  
1277 Deming Way  
Madison, Wisconsin 53717

Dear Mr. Palmer:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' report entitled "Duplicate Medicare Payments to Cost-Based Health Maintenance Organization Plans for Dean Health Plan, Inc. for the Fiscal Years 2000, through 2003." A copy of this report will be forwarded to the action official noted below for his/her review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports issued to the department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to report number A-05-05-00042 in all correspondence.

Sincerely yours,

Paul Swanson  
Regional Inspector General  
for Audit Services

Enclosures - as stated

**Direct Reply to HHS Action Official:**

Jackie Garner  
Regional Administrator  
Centers for Medicare & Medicaid Services - Region V  
233 North Michigan Avenue Suite 600  
Chicago Illinois 60601

**Fiscal Intermediary**

David Horst  
Vice President Medicare Operations  
WPS  
P.O. Box 8190  
Madison, Wisconsin 53708

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**DUPLICATE MEDICARE PAYMENTS  
TO COST-BASED HEALTH  
MAINTENANCE ORGANIZATIONS  
PLANS FOR DEAN HEALTH PLAN,  
INC. FOR THE FISCAL YEARS 2000,  
THROUGH 2003**



**Daniel R. Levinson  
Inspector General**

**AUGUST 2005  
A-05-05-00042**

# *Office of Inspector General*

<http://oig.hhs.gov>

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OIG's Office of Audit Services (OAS) provides all 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 in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

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**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**DUPLICATE MEDICARE PAYMENTS  
TO COST-BASED HEALTH  
MAINTENANCE ORGANIZATIONS  
PLANS FOR DEAN HEALTH PLAN,  
INC. FOR THE FISCAL YEARS 2000,  
THROUGH 2003**



**Daniel R. Levinson  
Inspector General**

**AUGUST 2005  
A-05-05-00042**

# *Notices*

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at <http://oig.hhs.gov>

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## **OAS FINDINGS AND OPINIONS**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Dean Heath Plan, Inc. (Dean) is a cost-based health maintenance organization (HMO) under contract with the Centers for Medicare & Medicaid Services (CMS) to provide health services on a prepayment basis to enrolled Medicare members. Dean receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs Dean expects to incur to provide Medicare covered services to enrollees. Dean claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Dean's annual Medicare reimbursement statement that compares its actual costs claimed to the total of the monthly interim payments. The governing regulations for costs claimed on the Medicare statement for payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR).

Wisconsin Physician Services (Carrier) is the Medicare Carrier through which Medicare payments and adjustments are processed for Dean.

Under cost-based or capitation arrangements, there is a potential for duplicate Medicare payments. This occurs when the costs of medical services included in the HMO's annual Medicare cost report are also reimbursed on a fee-for-service claim submitted directly by the medical service provider to Medicare. Dean was at risk for such duplicate payments because it had a sub-contracted capitation agreement with Dean Medical Center, Inc. (Medical Center). Under the agreement, Dean prepays the Medical Center a per-member, per-month dollar amount (capitation payment) to provide medical services to Dean's Medicare enrollees. To receive full payment under the capitation agreement for medical services provided to Dean's enrollees, the Medical Center submitted patient encounter forms to Dean. Since Dean included the capitation payments on its Medicare cost report, Medicare had in effect already reimbursed the Medical Center for its services. Consequently, any medical service claim covered by the capitation agreement and also paid by Medicare to the Medical Center, as a direct fee-for-service claim is a duplicate Medicare payment. Pursuant to Medicare Managed Care Manual, Chapter 17, Subchapter B, Dean, as a cost-based HMO, is required to establish a system to preclude and detect such duplicate payments for its medical service providers.

### **OBJECTIVE**

Our objective was to determine whether medical services provided for Dean's enrollees by the Medical Center were reimbursed under its capitation agreement and also through the Medicare fee-for-service payment system.

### **SUMMARY OF FINDINGS**

The Medical Center received duplicate Medicare payments of \$91,710 because Dean did not have proper Medicare reimbursement procedures in place for the fiscal years 2000, through

2003. Dean failed to establish required internal controls to detect Medicare fee-for-service billings by the Medical Center. The Medical Center received the duplicate Medicare payments by submitting Medicare fee-for-service claims for 1,487 lines of service that were already reimbursed through its capitation agreement with Dean. As a result, the Medical Center received Medicare payments through the Carrier and capitated payments from Dean.

## **RECOMMENDATIONS**

We recommend that Dean work cooperatively with the Medical Center and the Carrier to:

- recover the \$91,710 in duplicate Medicare fee-for-service claims made to the Medical Center, and
- develop an efficient and effective billing process system to preclude and detect duplicate payments from the Medical Center.

## **AUDITEE'S RESPONSE**

Dean agreed with our findings and has taken corrective actions to enhance their duplicate payment policies and procedures.

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## **INTRODUCTION**

### **BACKGROUND**

Dean Heath Plan, Inc. (Dean) is a cost-based health maintenance organization (HMO) under contract with the Centers for Medicare & Medicaid Services (CMS) to provide health services on a prepayment basis to enrolled Medicare members. Dean receives a monthly interim payment from CMS based on a per-capita rate for each Medicare enrollee. The payment covers the reasonable costs Dean expects to incur to provide Medicare covered services to enrollees. Dean claims the actual costs incurred on its annual certified Medicare cost report. A final settlement is made based on Dean's annual Medicare reimbursement statement that compares its actual costs claimed to the total of the monthly interim payments. The governing regulations for costs claimed for the Medicare payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR) and Medicare Managed Care Manual, Chapter 17, Subchapter B.

Wisconsin Physician Services (Carrier) is the Medicare Carrier through which Medicare payments and adjustments are processed for Dean.

Under cost-based or capitation arrangements, duplicate Medicare payments occur when the costs of medical services included in the HMO's annual Medicare cost report are also reimbursed on a fee for service basis to the medical service provider directly to Medicare. Dean was at risk for such duplicate payments because it had a sub-contracted capitation agreement, which prepaid Dean Medical Center, Inc. (Medical Center) a per-member, per-month dollar amount (capitation payment), to provide medical services to Dean's Medicare enrollees. To receive full payment under the capitation agreement for medical services provided to Dean's enrollees, the Medical Center submitted patient encounter forms to Dean. Since Dean included the capitation payments on its Medicare cost report, Medicare had in effect already reimbursed the Medical Center for its services. Consequently, any medical service claims covered by the capitation agreement, and also paid by Medicare to the Medical Center as a direct fee-for-service claim, was a duplicate Medicare payment. Pursuant to the Medicare Managed Care Manual, Chapter 17, Subchapter B, Dean, a cost-based HMO, is required to establish a system to preclude and detect such duplicate payments for its medical service providers.

### **OBJECTIVE, SCOPE, AND METHODOLOGY**

#### **Objective**

Our objective was to determine whether medical services provided for Dean's enrollees by the Medical Center were reimbursed under its Medicare capitation agreement and also through the Medicare fee-for-service payment system.

## Scope

We reviewed Medicare fee-for-service payments made to the Medical Center for fiscal years 2000, through 2003 as part of a region-wide review of potential overpayments made to capitated providers by cost-based HMOs. Due to the limited scope of our audit, we did not review overall internal control structures at either Dean or the Medical Center. However, we created a database specifically designed to identify duplicate payments, which was a specific test of the internal controls Dean had in place to preclude and detect such payments.

Our database was constructed in our field office in Lansing, Michigan. Since the database was the primary focus of our work, we did not conduct on-site work at either Dean or the Medical Center. We conducted telephone conference meetings with key personnel of Dean and obtained necessary audit documentation through regular and electronic mailings during May 2005.

The audit was conducted in accordance with generally accepted government auditing standards.

## Methodology

To accomplish the objective, we:

- reviewed applicable Federal laws and regulations and Medicare guidelines;
- reviewed and obtained an understanding of the capitation agreement between Dean and the capitated provider, the Medical Center;
- created a database of CMS fee-for-service claims paid to the Medical Center for covered services provided to Dean's enrollees, representing potential duplicate Medicare payments; and
- validated our database.

In order to create our database of duplicate payments, we used the CMS HMO Group enrollment files to identify health insurance claim numbers for Dean's enrollees from January 2000, through December 2003. We then matched these numbers against the CMS National Claims History Archive of Carrier Claims for the same time period. We requested and utilized Dean's enrollee information, which included starting and ending enrollment dates. To create our database, we extracted Medicare fee-for-service claims with a service date after the beginning enrollment date, and excluded those with a service date after the ending enrollment date. We obtained the Employer Identification Number (EIN) for Dean's sole capitated provider, the Medical Center and used the EINs to isolate the Medical Center's allowable services, per its capitation contract with Dean. The resulting database represented the duplicate reimbursement made through capitated and fee-for-service payments made to the Medical Center for 1,487 services to Dean's enrollees.

We presented our entire database to the Medicare claims processor, Wisconsin Physician Services (Carrier), that processes claims to determine whether the Medical Center had submitted any subsequent adjustments to its fee-for-service claims in our database. The Carrier stated that none of the claims in our database were adjusted.

Dean representatives stated that the fee-for-service claims in our database would be Medicare duplicates only if Dean had paid for the same services as listed on the encounter forms submitted by the Medical Center. Dean provided us with an automated file of the Medical Center's encounter data that was submitted during the audit period. Using the Medical Center's encounter data, we eliminated the fee-for-service claims paid by Medicare without a matching encounter.

## **FINDINGS AND RECOMMENDATIONS**

Dean failed to establish necessary internal controls to detect Medicare fee-for-service billings by the Medical Center, which allowed the Medical Center to receive duplicate Medicare payments of \$91,710 for the fiscal years 2000, through 2003. We determined that the Medical Center submitted 1,487 lines of fee-for service claims to Medicare that were already reimbursed under its capitation arrangement with Dean. Since Dean's capitation payments were included on its final Medicare settlement cost report, the Medical Center's fee-for-service claims caused Medicare to duplicate \$91,710 in payments to the Medical Center.

### **Regulations Regarding Cost-Based HMOs Responsibility to Detect Duplicate Payments**

The governing regulations for costs claimed on the Medicare payments made to cost-based HMOs are contained in Title 42 of the Code of Federal Regulations (CFR). HMO's receive monthly interim payments from CMS, based on a per-capita rate for each Medicare enrollee, to cover the reasonable costs incurred to provide Medicare covered services to their enrollees. These reasonable costs may include payments made by the HMO directly to providers who render Medicare services to the HMO's enrollees. The actual costs incurred by the HMOs are claimed on their annual certified Medicare cost report, and a final settlement is made based on a comparison of the actual costs claimed to the total of the monthly interim payments. An additional payment on a fee for service basis to the provider would represent a duplicate payment.

The legislative authority requiring the detection of duplicate payments is specified in the Medicare Managed Care Manual, Chapter 17, Subchapter B, entitled "Duplicate Payment Detection for Cost Contracting Health Care Prepayment Plans (HCPP) and HMO/ Competitive Medical Plans (CMP)" and states:

"Several entities may have jurisdiction over the processing and payment of Part B bills for your members. This could result in duplicate payments to either the physician, supplier, or to the enrollee. It is incumbent upon you to establish a system to preclude or detect duplicate payments.

. . . "Duplicate payment detection is the responsibility of the HCPP or HMO/CMP, not the carrier."

## **Dean's Failure to Detect Duplicate Payments**

We attribute the Medical Center's duplicate payments primarily to Dean's failure to establish required internal controls to detect the Medical Center's Medicare fee-for-service billings. Although we believe that the Medical Center should have had controls in its billing process to detect and prevent this condition, Dean, as a cost-based HMO, is ultimately responsible to ensure that the Medicare reimbursements contained in its final cost report settlement are not duplicated by fee-for-service claims submitted directly to Medicare by its contracted providers. During our audit period, Dean did not have an effective billing control system to detect duplicate payments.

## **RECOMMENDATIONS**

We recommend that Dean, work cooperatively with the Medical Center and the Carrier to:

- recover the \$91,710 duplicate Medicare fee for service claims made to the Medical Center and;
- develop an efficient and effective system to preclude and detect duplicate payments from the Medical Center.

## **AUDITEE'S RESPONSE**

Dean agreed with our findings and has taken corrective actions to enhance their duplicate payment policies and procedures.

# **APPENDIX**



July 26, 2005

Mr. Paul Swanson  
Regional Inspector General for Audit Services  
Department of Health and Human Services  
233 North Michigan Avenue  
Chicago, IL 60601

**Re: Audit Report # A-05-05-00042**

Dear Mr. Swanson:

We have received and reviewed the Office of the Inspector General (OIG) draft report entitled "Audit of Duplicate Medicare Payments to Cost-Based Health Maintenance Organizations (HMO) Plans for Dean Health Plan, Inc. for the Fiscal Years 2000, through 2003."

Dean Health Plan, Inc. (DHP) has been a cost-based HMO under contract with the Centers for Medicare & Medicaid Services (CMS) since the inception of the cost contract program. Prior to the cost-based contract, DHP had also provided health services to Medicare members through participation in the HCPP program. We appreciate the opportunity to provide health care services to Medicare members in our service area.

First, we would like to acknowledge the professional manner in which your audit staff undertook this engagement. Our claims and actuarial staff worked cooperatively with your audit team to provide the detail DHP encounter data and work through the reconciliation of our data and the Medicare Part B Carrier's claims data in a timely manner. We would however like to note that DHP did have policies and procedures in place and operating during the audit period and the procedures followed by our staff identified and corrected most potential duplicate payment situations. Yet, as noted, in the "Findings & Recommendation" the OIG audit team identified that our procedures designed to detect duplicate payments failed to identify and correct a small number of duplicate payments.



We have taken these audit findings as an opportunity to enhance our policies and procedures to insure that duplicate payment situations are detected and corrected timely.

The steps we have taken are as follows:

- CMS has not issued Final NPRs (Notice of Provider Reimbursement) to DHP for the Medicare Cost Reports years of 2000 through 2003. DHP will file amended cost reports for these years and deduct the \$91,710 in duplicate Medicare fee-for-service payments from "Reimbursable Costs" on the appropriate years' Medicare cost reports.
- DHP has billed and collected the \$91,710 of duplicate fee-for-service payments from Dean Medical Center.
- Policy and Procedures "XI Duplicate Payment Audit" has been updated and new procedures implemented to preclude and detect duplicate payments to Dean Medical Center. A copy of the updated Policy and Procedure is attached to this letter.

We believe that the steps listed above address the "Recommendations" made by the Office of the Inspector General in the June 2005 draft report. If you have any questions regarding this formal response, please do not hesitate to call me at (608) 827-4332.

Sincerely,

Robert W. Komula  
Senior Vice President & CFO

## **XI Duplicate Payment Audit**

APPENDIX  
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This audit is done monthly based on reports generated by the IT Department from the CMS Payment Record report. This report is usually dated two months before the processing month. The report is audited by a Claims Technician who specializes in the Dean Care Gold product to ensure no duplicate payments are made between DHP and CMS.

### **Creating the Reports**

A "Payment Record Report" is provided by CMS and downloaded by IT. The report is scanned for invalid Medicare numbers. That is numbers that begin with an alpha character. These records are excluded from the data pool. The data file is then converted into a SAS data set from the following fields:

- First nine characters of CMS member number – Report 0 lists all CMS member numbers that start with a letter instead of all digits.
- Name
- Date of Service
- Allowed Total Charges
- Reimbursement Amount

This SAS data set is then merged into a master file and is compared with our Sybase "MEDMAS" file. This is a review of 25 months worth of claims. The following criteria must be met in order for the records to be selected:

1. First nine characters of MHS member number must equal the first nine characters of the CMS member number report.
2. MHS date of service must equal CMS's date of service.
3. MHS billed amount must equal the allowed total billed from CMS.

Then the MHS paid amount is added to the CMS reimbursement amount and compared to the MHS claim amount. Three separate reports are generated from this process. The reports will list the date of data from CMS as well as received date at DHP.

**Report 1:** Lists all records that match on member number, date of service, claim amount.

**Report 2:** Lists all records where MHS paid amount is equal or greater than CMS reimbursement amount.

**Report 3:** Lists all records where the sum of the MHS paid amount plus CMS reimbursement amount is greater than the MHS claim amount. This is frequently empty.

## **XI Duplicate Payment Audit**

APPENDIX  
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### **Working the Reports**

1. Review all matches in Report 1 listed under (Using Input File) and highlight the MHS claims where MHS paid amount and CMS paid amount is equal or greater than the claim amount. This is a check for Report 2 and 3.
2. Review all matches on Report 2 listed under (DEAN paid amount = or > CMS paid amount) and highlight MHS claims where MHS paid amount and CMS paid is equal or greater than the claim amount. Compare against highlights in Report 1.
3. Review all matches in Report 3 listed under (Total Paid > Claim Amount) and repeat as in Step 2. Total number of highlights in Report 1 equal Reports 2 and 3 and provider is over paid. There should be few or no matches on this report.
4. Run through the highlighted claims to see if there are any Medigap Crossover claims. It is possible for some lines on multiple line claims to hit on the reports as the COB amount is brought down in full compared to the usual 80% CMS reimbursement. This only happens on claims submitted prior to December 2003.
5. Reverse the highlighted claims using the (A01) reversal code and reprocess the claims using the CMS reimbursement as the COB amount when the MHS paid amount is greater than the CMS reimbursement amount and pay the providers as secondary. When a highlighted claim shows a service being paid in full by both MHS and CMS, reverse the line on the claims using the (A01) reversal code and add a (Y5) message code.
6. Contact Provider Services Department with any unusual billing problems noted from any individual providers, so that they can be contacted and educated on proper billing procedures.

### **Additional Procedures Related to Dean Medical Center**

1. Each month, an eligibility file update is generated and sent to DMC so they can ensure that proper coverage information is loaded onto their systems for all DHP Gold members. By loading accurate coverage information onto their system, this ensures the applicable claims are routed to DHP instead of directly to CMS.
2. Periodically, the list of procedures which are excluded from processing by DHP will be reviewed and updated by DMC staff.
3. When a duplicate claim is identified and amended (per procedures above), DMC staff will adjust their systems appropriately to ensure an accurate reflection of the service as it relates to cost-based encounter reporting.

## **XI Duplicate Payment Audit**

APPENDIX  
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4. DHP will complete one final test of the encounter data before it is used to compute the Related Party cost for the Final Cost report. DHP will review MHS claims data where Medicare has already processed and compare to the encounter data provided by DMC. If any of these services appear, the encounter will be excluded from the allowable costs on the Cost report, to avoid any duplicate payment by CMS.

# ACKNOWLEDGMENTS

This report was prepared under the direction of Paul Swanson, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Stephen Slamar, Audit Manager

Tammie Anderson, Audit Manager – Advanced Audits Technique Staff

Denise Novak, Senior Auditor

Tom Caughey, Auditor-in-Charge

Kathryn Benson, Auditor

Nanette Sanchez, Auditor