



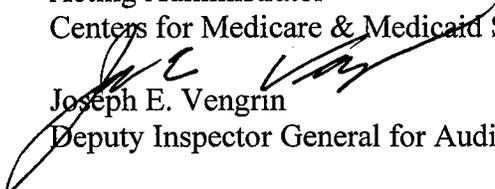
DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

NOV - 1 2006

**TO:** Leslie V. Norwalk, Esq.  
Acting Administrator  
Centers for Medicare & Medicaid Services

**FROM:**   
Joseph E. Vengrin  
Deputy Inspector General for Audit Services

**SUBJECT:** Review of Fee-for-Service Payments for Medicare Beneficiaries Enrolled in Managed Care Risk Plans (A-07-05-01016)

Attached is a copy of our final report on fee-for-service payments for Medicare beneficiaries enrolled in managed care risk plans. Our objective was to determine whether the fiscal intermediaries complied with Federal regulations in making fee-for-service payments to hospitals for inpatient services furnished to Medicare managed care organization (MCO) beneficiaries. Our audit included beneficiaries who were enrolled in MCOs nationwide for at least 1 month during calendar years 2003 and 2004.

In October 1999, we issued a report (A-07-97-01247) regarding duplicate payments in four States totaling \$2.3 million for 3 years for beneficiaries enrolled in MCOs. We recommended that the Centers for Medicare & Medicaid Services (CMS) strengthen procedures to prevent and detect duplicate payments when the MCO has payment responsibility.

Our current review found that the fiscal intermediaries did not always comply with Federal regulations in making fee-for-service payments to hospitals for inpatient services furnished to Medicare MCO beneficiaries. The intermediaries incorrectly paid 803 fee-for-service inpatient claims for beneficiaries who were enrolled in MCOs:

- For 692 claims, the MCO enrollment data were recorded on the Group Health Plan before the intermediaries paid the claims.
- For 111 claims, the MCO enrollment data were not recorded on the Group Health Plan before the intermediaries paid the claims.

We provided CMS with a spreadsheet of the errors and discussed the causes of incorrectly paid claims with CMS officials.

The intermediaries paid some of the claims because enrollment data were not always updated correctly from the Group Health Plan to the Common Working File. CMS did not know why the intermediaries incorrectly paid the other claims or why the intermediaries did not recover the fee-for-service payments made during the retroactive periods. Because

CMS paid MCOs to provide all medically necessary services for these beneficiaries, payments for the fee-for-service claims totaling \$4.6 million were duplicate payments.

We recommend that CMS:

- direct the fiscal intermediaries to recoup the \$4.6 million of duplicate payments and
- periodically compare the Group Health Plan with the Common Working File, reconcile any discrepancies in enrollment data, and have the fiscal intermediaries take necessary action on apparent duplicate payments.

In written comments on our draft report, CMS concurred with our recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at [George.Reeb@oig.hhs.gov](mailto:George.Reeb@oig.hhs.gov). Please refer to report number A-07-05-01016 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF FEE-FOR-SERVICE  
PAYMENTS FOR MEDICARE  
BENEFICIARIES ENROLLED IN  
MANAGED CARE RISK PLANS**



Daniel R. Levinson  
Inspector General

November 2006  
A-07-05-01016

# ***Office of Inspector General***

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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**

At the beginning of each month, the Centers for Medicare & Medicaid Services (CMS) makes capitation payments to risk-based managed care organizations (MCO) for each enrolled Medicare beneficiary. MCOs must arrange and pay for all medically necessary services. Beneficiaries who are enrolled in MCOs are required to use the MCOs' physicians, hospitals, and affiliated providers.

CMS is responsible for ensuring that Medicare payments are made correctly. Each month, MCOs transmit enrollment data to CMS, including when each Medicare beneficiary enrolled and/or disenrolled. CMS maintains the enrollment data on the Group Health Plan, a system that is supposed to contain data on every Medicare beneficiary enrolled in an MCO. CMS uses the enrollment data on the Group Health Plan to update the Common Working File, which is supposed to contain eligibility information for every Medicare beneficiary. CMS also contracts with fiscal intermediaries to make payments to hospitals for inpatient services. The intermediaries make payments on a fee-for-service basis, i.e., hospitals receive a separate payment for each inpatient service.

For inpatient claims, the beneficiary's MCO status on the hospital admission date determines whether the MCO or the intermediary has payment responsibility. MCOs have payment responsibility for claims with services that began on or after the MCO enrollment date. The intermediaries have payment responsibility for claims with services that began before the MCO enrollment date. To avoid paying for the same service twice, Federal regulations prohibit intermediaries from paying providers on a fee-for-service basis for Medicare beneficiaries enrolled in MCOs.

We issued a report to CMS in October 1999 (A-07-97-01247) regarding duplicate payments in four States totaling \$2.3 million for 3 years for beneficiaries enrolled in MCOs. We recommended that CMS strengthen procedures to prevent and detect duplicate payments when the MCO has payment responsibility.

### **OBJECTIVE**

Our objective was to determine whether the fiscal intermediaries complied with Federal regulations in making fee-for-service payments to hospitals for inpatient services furnished to Medicare MCO beneficiaries.

### **SUMMARY OF FINDINGS**

The fiscal intermediaries did not always comply with Federal regulations in making fee-for-service payments to hospitals for inpatient services furnished to Medicare MCO beneficiaries. The intermediaries incorrectly paid 803 fee-for-service inpatient claims for beneficiaries who were enrolled in MCOs:

- For 692 claims, the MCO enrollment data were recorded on the Group Health Plan before the intermediaries paid the claims.
- For 111 claims, the MCO enrollment data were not recorded on the Group Health Plan before the intermediaries paid the claims.

The intermediaries paid some of the claims because enrollment data were not always updated correctly from the Group Health Plan to the Common Working File. CMS did not know why the intermediaries incorrectly paid the other claims or why the intermediaries did not recover the fee-for-service payments made during the retroactive periods. Because CMS paid MCOs to provide all medically necessary services for these beneficiaries, payments for the fee-for-service claims totaling \$4.6 million were duplicate payments.

## **RECOMMENDATIONS**

We recommend that CMS:

- direct the fiscal intermediaries to recoup the \$4.6 million of duplicate payments and
- periodically compare the Group Health Plan with the Common Working File, reconcile any discrepancies in enrollment data, and have the fiscal intermediaries take necessary action on apparent duplicate payments.

## **AUDITEE'S COMMENTS**

In written comments on our draft report, CMS concurred with our recommendations. CMS's comments are included as the Appendix.

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# INTRODUCTION

## BACKGROUND

### Medicare Managed Care

The Balanced Budget Act of 1997, Public Law 105-33, established the Medicare+Choice program to provide a wider range of health plan choices to Medicare beneficiaries.<sup>1</sup> The choices include coordinated care plans, medical savings account plans, and private fee-for-service plans. Pursuant to 42 CFR § 422.4(a)(1), a coordinated care plan, formally known as a risk-based managed care organization (MCO), is “a plan that includes a network of providers that are under contract or arrangement with [an] organization to deliver the benefit package approved by CMS [the Centers for Medicare & Medicaid Services].” MCOs include health maintenance organizations, provider sponsored organizations, and preferred provider organizations.

At the beginning of each month, CMS makes capitation payments to MCOs for each enrolled Medicare beneficiary. MCOs must arrange and pay for all medically necessary services. Beneficiaries who are enrolled in MCOs are required to use the MCOs’ physicians, hospitals, and affiliated providers. Enrollees are responsible for payments for services from providers outside the MCO network (except for emergency services and services denied and later approved on appeal).

### Medicare Fee-for-Service

CMS administers Medicare fee-for-service largely through an administrative structure of claims-processing contractors. Fiscal intermediaries process Medicare Part A claims submitted by institutional providers, such as hospitals, skilled nursing facilities, hospices, and home health agencies.

Hospitals submit a bill to a fiscal intermediary for each Medicare patient who receives an inpatient service. Based on the information provided on the bill, the intermediary pays the hospital for the specific service. Hospitals should not receive payments directly from CMS for MCO enrollees.

### Payment Responsibility

CMS is responsible for ensuring that Medicare payments are made correctly. Each month, MCOs transmit enrollment data to CMS, including when each Medicare beneficiary enrolled and/or disenrolled in their plans. CMS maintains the enrollment data on the Group Health Plan, a system that is supposed to contain data on every Medicare beneficiary enrolled in an MCO. CMS uses the enrollment data on the Group Health Plan to update the enrollment data in the Common Working File, which is supposed to contain eligibility information for every Medicare beneficiary.

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<sup>1</sup>Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the Medicare+Choice Plans are now called Medicare Advantage Plans.

For inpatient claims, the beneficiary's MCO status on the hospital admission date determines whether the MCO or the fiscal intermediary has payment responsibility. MCOs have payment responsibility for claims with services that began on or after the MCO enrollment date. The intermediaries have payment responsibility for claims with services that began before the MCO enrollment date.

CMS has instructed the intermediaries to search the Common Working File to determine whether to pay or reject fee-for-service claims. The intermediaries query the Common Working File for beneficiary enrollment data for all inpatient claims received from hospitals. If the MCO enrollment data in the Common Working File indicate that the beneficiary is a member of an MCO, the intermediary should deny the claim; however, there are some exceptions. For example, a provider may be reimbursed on a fee-for-service basis for MCO enrollees who elect hospice coverage or receive a service classified as a national coverage determination.<sup>2</sup>

### **Retroactive Enrollment**

A retroactive enrollment occurs when enrollment data are entered in the Group Health Plan after the beneficiary's actual enrollment date. For example, if a beneficiary enrolled in an MCO on January 1, 2005, but the enrollment data were not entered in the Group Health Plan until January 30, 2005, the Group Health Plan would retroactively list the actual enrollment date as January 1, 2005. The actual enrollment date should then be updated in the Common Working File.

When retroactive enrollments from the Group Health Plan are updated in the Common Working File, CMS has instructed the intermediaries to search the Common Working File for claims that were erroneously approved for payment during the period of retroactive MCO enrollment. For claims identified during the retroactive period, the intermediary must attempt to recover the original fee-for-service payment from the provider.

### **Previous Audit Report**

We issued a report to CMS in October 1999 (A-07-97-01247) regarding duplicate fee-for-service payments in four States totaling \$2.3 million for 3 years for beneficiaries enrolled in MCOs. We recommended that CMS strengthen procedures to prevent and detect duplicate payments when the MCO has payment responsibility.

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

### **Objective**

Our objective was to determine whether the fiscal intermediaries complied with Federal regulations in making fee-for-service payments to hospitals for inpatient services furnished to Medicare MCO beneficiaries.

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<sup>2</sup>A national coverage determination indicates coverage for a new service that was not included in the calculation of the managed care capitation payment.

## **Scope**

Our audit included beneficiaries who were enrolled in MCOs nationwide for at least 1 month during calendar years 2003 and 2004. We reviewed internal controls to the extent necessary to accomplish the audit objective.

## **Methodology**

We reviewed Federal regulations related to payment liability for Medicare beneficiaries enrolled in MCOs. We also reviewed the program manuals and memorandums that CMS issued to fiscal intermediaries that provided instructions on which claims to pay.

We used the Group Health Plan to identify beneficiaries enrolled in MCOs during 2003 and 2004. We obtained inpatient claim data from the National Claims History and Standard Analytical Files for those beneficiaries enrolled in MCOs. We identified fee-for-service inpatient claims that began on or after the date that the beneficiary enrolled in the MCO and before the beneficiary disenrolled (if applicable) from the MCO. We classified such paid claims as errors, except for enrollees who elected hospice coverage before the hospital admission date or received a service classified as a national coverage determination. We also eliminated claims from hospitals that were not reimbursed under the prospective payment system if the beneficiary disenrolled from the MCO before his or her hospital discharge date. Using information in the Common Working File as of August 2005, we verified the accuracy of the payment amount and ensured that the payment had not been canceled. For selected beneficiaries, we compared Group Health Plan enrollment data with the enrollment data in the Common Working File.

We provided CMS with a spreadsheet of the errors and discussed the causes of incorrectly paid claims with CMS officials.

We conducted our audit in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

The fiscal intermediaries did not always comply with Federal regulations in making fee-for-service payments to hospitals for inpatient services furnished to Medicare MCO beneficiaries. The intermediaries incorrectly paid 803 fee-for-service inpatient claims for beneficiaries who were enrolled in MCOs:

- For 692 claims, the MCO enrollment data were recorded on the Group Health Plan before the intermediaries paid the claims.
- For 111 claims, the MCO enrollment data were not recorded on the Group Health Plan before the intermediaries paid the claims.

The intermediaries paid some of the claims because enrollment data were not always updated correctly from the Group Health Plan to the Common Working File. CMS did not know why the intermediaries incorrectly paid the other claims or why the intermediaries did not recover the fee-for-service payments made during the retroactive periods. Because CMS paid MCOs to provide

all medically necessary services for these beneficiaries, payments for the fee-for-service claims totaling \$4.6 million were duplicate payments.

## **PAYMENT RESPONSIBILITY AND CLAIMS PROCESSING**

Pursuant to 42 CFR § 412.20(d)(3), inpatient hospital services will not be paid on a fee-for-service basis if “The services are paid for by an [MCO] . . . that elects not to have CMS make payments directly to a hospital for inpatient hospital services furnished to the [MCO’s] . . . Medicare enrollees.”

CMS’s manuals instruct hospitals and fiscal intermediaries about the payment liability for inpatient services for Medicare MCO enrollees. Section 408 of the “Hospital Manual” states: “If you are a PPS [prospective payment system] hospital and the patient changes his [MCO] status during an inpatient stay, his status at admission determines liability. If he was enrolled in the [MCO] before admission, the [MCO] is responsible regardless of whether he disenrolled before discharge.” Section 3654.1 of the “Medicare Intermediary Manual” instructs intermediaries to “not make a duplicate payment for the same services the [MCO] has paid.”

Pursuant to 42 CFR § 422.101(a), MCOs must “Provide coverage of, by furnishing, arranging for, or making payment for, all services that are covered by Part A and Part B of Medicare . . . .”

## **INCORRECT FEE-FOR-SERVICE PAYMENTS**

The fiscal intermediaries incorrectly paid 803 fee-for-service inpatient claims for beneficiaries who were enrolled in MCOs before they were admitted to the hospital.

### **Enrollment Data Recorded on the Group Health Plan Before Payment**

For 692 of the 803 claims, the MCO enrollment data were recorded on the Group Health Plan before the fiscal intermediaries paid the fee-for-service claims.

For some of the 692 claims, the MCO enrollment data were not updated correctly from the Group Health Plan to the Common Working File. Specifically, the beneficiary’s enrollment and/or disenrollment dates listed in the Common Working File differed from those listed on the Group Health Plan. Because the intermediaries used the Common Working File to determine when to pay fee-for-service claims, they may have incorrectly paid the claims because of inaccurate information. For example, one beneficiary’s inpatient admission date was October 20, 2004, but the enrollment and disenrollment dates were listed on the systems as follows:

Common Working File and Group Health Plan enrollment date:	07/01/2000
Group Health Plan disenrollment date:	10/31/2004
Common Working File disenrollment date:	09/30/2004

If the intermediary had used the Common Working File disenrollment date of September 30, 2004, it would have paid the claim because it would have believed that the beneficiary was no longer enrolled in an MCO. However, the Group Health Plan indicated that the beneficiary was enrolled between July 1, 2000, and October 31, 2004; therefore, the beneficiary was still enrolled

in an MCO as of the inpatient admission date of October 20, 2004, and the intermediary should not have paid the fee-for-service claim.

CMS officials stated that they did not know why the intermediaries incorrectly paid the remaining claims.

### **Enrollment Data Not Recorded on the Group Health Plan Before Payment**

For the remaining 111 claims, the MCO enrollment data were not recorded on the Group Health Plan before the fiscal intermediary paid the claims.

The MCO enrollment data are generally entered in the Group Health Plan before the effective enrollment date; however, retroactive adjustments may occur when the enrollment data are entered in the Group Health Plan after the effective date. CMS has issued specific instructions to intermediaries to collect from providers fee-for-service payments made during these retroactive periods.

CMS officials stated that they did not know why the intermediaries did not recover the fee-for-service payments made during these retroactive periods.

### **Duplicate Payments**

Because CMS paid MCOs to provide all medically necessary services for these beneficiaries, payments for the fee-for-service claims totaling \$4.6 million were duplicate payments.

## **RECOMMENDATIONS**

We recommend that CMS:

- direct the fiscal intermediaries to recoup the \$4.6 million of duplicate payments and
- periodically compare the Group Health Plan with the Common Working File, reconcile any discrepancies in enrollment data, and have the fiscal intermediaries take necessary action on apparent duplicate payments.

## **AUDITEE'S COMMENTS**

In written comments on our draft report, CMS concurred with our recommendations. Specifically, CMS agreed that the overpayments identified as duplicate payments should be recovered and stated that it had taken steps to recover the overpayments consistent with the agency's policies and procedures. CMS also agreed to expedite timely reconciliation of discrepancies in enrollment data with the Common Working File and to have Medicare contractors recoup monies paid in error. CMS's comments are included as the Appendix.

CMS also provided technical comments, which we addressed as appropriate.

# **APPENDIX**



## DEPARTMENT OF HEALTH &amp; HUMAN SERVICES

Centers for Medicare &amp; Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** SEP 11 2006

**TO:** Daniel R. Levinson  
Inspector General  
Office of Inspector General

**FROM:** Mark B. McClellan, MD., PhD. *MM*  
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Review of Fee-for-Service Payments for Medicare Beneficiaries Enrolled in Managed Care Risk Plans" (A-07-05-01016)

Thank you for the opportunity to review and comment on the draft report concerning payments made by fee-for-service (FFS) contractors for Medicare beneficiaries enrolled in managed care risk plans. We are also concerned about the accuracy of payments and we have taken a number of actions to address the incorrect payments referenced in the report and to improve payment accuracy overall. First, in May 2006, CMS issued new instructions to FFS contractors on the collection of fee-for-service payments made during periods of MA enrollment (Transmittal 97, Publication 100-06 Medicare Financial Management). This transmittal will ensure that any claims erroneously approved for payment by a FFS contractor are submitted to the normal collection process used by the contractors for overpayments.

Specifically, the contractors are instructed to:

- Initiate overpayment recovery procedures to retract the original Part A and Part B payment including sending an adjustment to CWF to cancel or update both CWF and contractor history.
- Upon receipt of an adjustment for the fee-for-service claim on history, CWF will update the deductible and return the corrected deductible information to the contractor.
- Carriers are to recover any monies due back to Medicare resulting from these denials by following the standard or (customary) recovery process.

Second, CMS provided a cd-rom with a listing of the claims in question to those contractors responsible for geographic areas where a large majority of the retroactive MA enrollments occurred.

Third, CMS has conducted outreach to providers to inform them of CMS' solution to this problem and how it affects them. Educational outreach activities were:

- Issuance of MLN 5074 through the MLN Matters listserv (to 27,500 subscribers). This article can be found on the CMS website at [www.cms.hhs.gov/MLNMattersArticles](http://www.cms.hhs.gov/MLNMattersArticles). Contractors were instructed to post this article, or a direct link to this article, on their Web

site and include information about it in a listserv message within 1 week of the availability of the provider education article. In addition, contractors were instructed to include this article in their next regularly scheduled bulletin and incorporate into any educational events on this topic. Contractors were free to supplement MLN Matters articles with localized information that would benefit their provider community in billing and administering the Medicare program correctly.

- Issuance of a notice sent to over 90 national associations and over 1,000 state and local associations through Regional Office Outreach staff.
- Issuance of a notice on CMS' provider listservs (to 115,600 subscribers).

In summary, CMS agrees that these overpayments identified as duplicate payments should be recovered, and we believe the steps we have taken address the OIG's concerns. We provide additional technical comments on the report in the Attachment.

Attachment

**Centers for Medicare & Medicaid Services' Comments to the Office of the  
Inspector General (OIG) Draft Report Entitled: Review of Fee-for-Service Payments for  
Medicare Beneficiaries Enrolled in Managed Care Risk Plans  
(A-07-05-01016)**

**OIG Recommendation**

Direct the fiscal intermediaries to recoup the \$4.6 million of duplicate payments and - CMS Response (Concur)

**CMS Response**

The CMS agrees that the overpayments identified as duplicate payments should be recovered. CMS has taken steps to recover the overpayments consistent with the agency's policies and procedures.

**OIG Recommendation**

Periodically compare the Group Health Plan with the Common Working File, reconcile any discrepancies in enrollment data, and have the fiscal intermediaries take necessary action on apparent duplicate payments.

**CMS Response**

We concur. The CMS implemented change request 5015 to expedite timely reconciliation of discrepancies in enrollment data with the Common Working File (CWF).

In October 2003, the Common Working File (CWF) implemented a process where claims processed/approved for payment erroneously as fee for service were identified. This identification process is called Informational Unsolicited Response (IUR) and the claims were for beneficiaries enrolled in Managed Care Risk Plans. Just recently CR5105 was created to manualize the process.

As part of the IUR process Medicare contractors are required to recoup monies paid in error.

The Group Health Plan system no longer exists, it is now called MARx/HPMS and it is the source of plan information. CWF does not have a direct feed with MARx/HPMS, therefore a periodic compare does not happen. However, CWF does update beneficiary plan information when discrepancies are identified.