DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region I
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203
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September 14, 2011

Report Number: A-01-11-00520

Mr. Neal Burkhead
Vice President and J11 Program Manager
Palmetto GBA, LLC
17 Technology Circle
Columbia, SC 29203-9591

Dear Mr. Burkhead:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Outpatient Claims Processed by Palmetto GBA That Included Procedures for the Insertion of Multiple Units of the Same Type of Medical Device for Calendar Years 2008 and 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, or contact David Lamir, Audit Manager, at (617) 565-2704 or through email at David.Lamir@oig.hhs.gov. Please refer to report number A-01-11-00520 in all correspondence.

Sincerely,

/Michael J. Armstrong/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly
Consortium Administrator
Consortium for Financial Management & Fee for Service Operations
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTPATIENT CLAIMS PROCESSED BY PALMETTO GBA THAT INCLUDED PROCEDURES FOR THE INSERTION OF MULTIPLE UNITS OF THE SAME TYPE OF MEDICAL DEVICE IN CALENDAR YEARS 2008 AND 2009

Daniel R. Levinson
Inspector General

September 2011
A-01-11-00520

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

The Centers for Medicare & Medicaid Services (CMS) administers the Medicare program. CMS employs Medicare contractors, including Palmetto GBA, LLC (Palmetto), to process and pay hospital outpatient claims using the Fiscal Intermediary Shared System (FISS).

CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the ambulatory payment classification group to which the service is assigned. Under the OPPS, outlier payments are available when exceptionally costly services exceed established thresholds.

Common medical devices implanted during outpatient procedures include cardiac devices, joint replacement devices, and prosthetics. Generally, a provider implants only one cardiac device during an outpatient surgical procedure. Under the OPPS, payments to hospitals for medical devices are "packaged" into the payment for the procedure to insert the device. Hospitals are required to report the number of device units and related charges accurately on their claims. The failure to report device units and related charges accurately could result in incorrect outlier payments.

Our audit covered $155,055 in Medicare outlier payments to hospitals for 45 claims for outpatient procedures that included the insertion of more than 1 of the same type of medical device. The 45 claims had dates of service during calendar years (CY) 2008 and 2009.

OBJECTIVE

Our objective was to determine whether Medicare paid hospitals correctly for outpatient claims processed by Palmetto that included procedures for the insertion of multiple units of the same type of medical device.

SUMMARY OF FINDINGS

Of the 45 claims that we reviewed, Medicare paid 32 correctly for outpatient claims processed by Palmetto that included procedures for the insertion of multiple units of the same type of medical device. However, for the remaining 13 claims, Medicare did not pay hospitals correctly. These incorrect payments were due to hospitals overstating the number of units and related charges, resulting in excessive or unwarranted outlier payments for 12 claims; hospitals also understated the number of units and related charges, resulting in a reduced outlier payment for 1 claim.

For the 13 claims, Palmetto made net overpayments to hospitals totaling $40,678. Incorrect payments occurred because hospitals had inadequate controls to ensure that

they billed accurately for claims that included the insertion of medical devices. In addition, Medicare payment controls in the FISS were not always adequate to prevent or detect incorrect payments.

RECOMMENDATIONS

We recommend that Palmetto:

- recover the $40,678 in net overpayments for 13 inaccurate claims,
- continue to alert hospitals of the importance of coding outpatient claims with the correct number of medical device units, and
- work with CMS to strengthen FISS prepayment edits by revising the unit amount thresholds for certain medical devices.

PALMETTO GBA COMMENTS

In written comments on our draft report, Palmetto concurred with our findings and recommendations and outlined steps for implementing our recommendations. Palmetto's comments are included in their entirety as the Appendix.

TABLE OF CONTENTS

Page

INTRODUCTION 1

BACKGROUND 1
Hospital Outpatient Prospective Payment System 1
Medical Devices 1

OBJECTIVE, SCOPE, AND METHODOLOGY 2
Objective 2
Scope 2
Methodology 2

FINDINGS AND RECOMMENDATIONS 3

PROGRAM REQUIREMENTS 3

PAYMENTS BASED ON CLAIMS BILLED INCORRECTLY 4

CAUSES OF INCORRECT PAYMENTS 4
Inadequate Controls at Hospitals 4
Inadequate Medicare Payment Controls 4

RECOMMENDATIONS 5

PALMETTO GBA COMMENTS 5

APPENDIX

PALMETTO GBA COMMENTS

INTRODUCTION

BACKGROUND

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

CMS contracted with Palmetto GBA, LLC (Palmetto) to, among other things, process and pay claims submitted by hospital outpatient departments. Palmetto uses the Fiscal Intermediary Shared System (FISS) for processing hospital claims. Palmetto processes claims for California, Hawaii, Nevada, American Samoa, Guam, Northern Mariana Islands, North Carolina, South Carolina, West Virginia, Virginia, and Ohio.

Hospital Outpatient Prospective Payment System

As mandated by the Balanced Budget Act of 1997, P.L. No. 105-33, together with the Medicare, Medicaid, and SCHIP (State Children's Health Insurance Program) Balanced Budget Refinement Act of 1999, P.L. No. 106-113. CMS implemented an outpatient prospective payment system (OPPS) for hospital outpatient services. The OPPS was effective for services furnished on or after August 1, 2000. Under the OPPS, Medicare pays for hospital outpatient services on a rate-per-service basis that varies according to the assigned ambulatory payment classification (APC). All services and items within an APC group are comparable clinically and require comparable resources. Under the OPPS, outlier payments are available when exceptionally costly services exceed established thresholds.

Medical Devices

Common medical devices implanted during outpatient procedures include cardiac devices, joint replacement devices, and prosthetics. Generally, a provider implants only one cardiac device, such as a pacemaker or implantable cardioverter defibrillator (ICD), during an outpatient surgical procedure.

Under the OPPS, payments to hospitals for medical devices are "packaged" into the payment for the procedure to insert the device. Although separate payment is not made for the device, hospitals are required to report the number of device units and related charges accurately on their claims. The failure to report device units and related charges accurately could result in incorrect outlier payments.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare paid hospitals correctly for outpatient claims processed by Palmetto that included procedures for the insertion of multiple units of the same type of medical device.

Scope

Our audit covered $155,055 in Medicare outlier payments to hospitals for 45 claims for outpatient procedures that included the insertion of more than 1 of the same type of medical device. The 45 claims had dates of service during calendar years (CY) 2008 and 2009.

Our objective did not require an understanding or assessment of the complete internal control structures of the hospitals or Palmetto. Therefore, we limited our review at hospitals to the controls related to preparing and submitting Medicare claims for procedures that included the insertion of selected medical devices. We limited our review at Palmetto to the controls related to preventing or detecting Medicare overpayments to hospitals for outpatient claims with overstated medical device units.

Our fieldwork included contacting Palmetto and the 29 hospitals that submitted the 45 claims in our review. We conducted our fieldwork from September 2010 through February 2011.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted hospitals' outpatient paid claim data from CMS's National Claims History file for CYs 2008 and 2009;
- developed computer applications to identify outpatient claims processed by Palmetto that included procedures for the insertion of multiple units of the same type of medical device and identified 45 claims;
- reviewed the hospitals' itemized bills for 45 claims and selected beneficiaries' medical records to determine whether the hospitals submitted the claims with the correct device units and associated charges;
- reviewed CMS's Common Working File claims history for the 45 claims to validate the results of our computer match and to verify that the selected claims had not been canceled;

- contacted representatives of the 29 hospitals that submitted the claims to verify whether the claims were billed correctly and to determine the causes of noncompliance with Medicare billing requirements;

- contacted Palmetto to obtain an understanding of edits in the FISS and other controls intended to prevent or detect overpayments to hospitals;

- calculated the correct payments for claims that needed payment adjustments; and

- discussed the results of our review with Palmetto.

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 45 claims that we reviewed, Medicare paid 32 correctly for outpatient claims processed by Palmetto that included procedures for the insertion of multiple units of the same type of medical device. However, for the remaining 13 claims, Medicare did not pay hospitals correctly. These incorrect payments were due to hospitals overstating the number of units and related charges, resulting in excessive or unwarranted outlier payments for 12 claims; hospitals also understated the number of units and related charges, resulting in a reduced outlier payment for 1 claim.

For the 13 claims, Palmetto made net overpayments to hospitals totaling $40,678. Incorrect payments occurred because hospitals had inadequate controls to ensure that they billed accurately for claims that included the insertion of medical devices. In addition, Medicare payment controls in the FISS were not always adequate to prevent or detect incorrect payments.

PROGRAM REQUIREMENTS

Section 1862(a)(1)(A) of the Act states that no payment may be made under Part A or Part B for any expenses incurred for items or services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

The *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 1, §80.3.2.2, requires that claims be completed accurately to be processed correctly and promptly.

Federal regulations (42 CFR §419.43(d)) provides for outlier payments for hospital outpatient services, in addition to the prospective payment, when a hospital's charges exceed certain thresholds.

PAYMENTS BASED ON CLAIMS BILLED INCORRECTLY

Hospitals incorrectly billed medical device units for 13 of the 45 claims, resulting in net overpayments totaling $40,678. These billing errors led to overstated charges, resulting in excessive or unwarranted outlier payments for 12 claims, and understated charges, resulting in an underpayment for 1 claim.

The following are examples of incorrectly billed units:

- One hospital billed for two automatic implantable cardioverter defibrillator (AICD) units with charges that totaled $130,200. However, the hospital should have billed for one AICD unit with charges of $65,100. The additional charges for the second AICD unit resulted in an unwarranted outlier payment of $8,676.04 to the hospital.

- One hospital billed for six units of neurostimulator leads with charges that totaled $42,750, but it should have billed for seven units with charges of $49,875. The omission of the charge for the additional unit resulted in the hospital receiving an outlier payment that was $10,177.52 less than it was entitled.

CAUSES OF INCORRECT PAYMENTS

Inadequate Controls at Hospitals

The 11 hospitals that received incorrect payments had not established the necessary controls to ensure that they billed the correct device units for outpatient claims processed by Palmetto that included procedures for the insertion of medical devices. Officials of these hospitals stated that their billing personnel had billed units incorrectly for one or more of the following reasons:

- Personnel made isolated data entry errors.

- Multiple personnel mistakenly entered the same device charges on the same claim.

- Undetected flaws in the design or implementation of some billing systems caused some claims to be submitted with multiple medical device units.

Inadequate Medicare Payment Controls

Medicare payment controls were not always adequate to prevent or detect incorrect payments. Specifically, CMS established, as part of its FISS prepayment controls, unit amount thresholds for medically unlikely edits that are too high for certain medical devices (i.e., currently, there is a two-unit threshold for pacemakers).

RECOMMENDATIONS

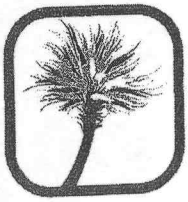
We recommend that Palmetto:

- recover the $40,678 in net overpayments for the 13 inaccurate claims,
- continue to alert hospitals of the importance of coding outpatient claims with the correct number of medical device units, and
- work with CMS to strengthen FISS prepayment edits by revising the unit amount thresholds for certain medical devices.

PALMETTO GBA COMMENTS

In written comments on our draft report, Palmetto concurred with our findings and recommendations and outlined steps for implementing our recommendations. Palmetto's comments are included in their entirety as the Appendix.

APPENDIX



Palmetto GBA℠
PARTNERS IN EXCELLENCE℠

Bruce W. Hughes
President and Chief Operating Officer

August 25, 2011

Michael J. Armstrong
Office of Inspector General
Office of Audit Services, Region I
John F. Kennedy Federal Building Room 2425
Boston, MA 02203

Reference: Report No. A-01-11-00520

Dear Mr. Armstrong:

This letter is in response to the recent Office of Inspector General (OIG) report entitled "*Review of Outpatient Claims Processed by Palmetto GBA, LLC That Included Procedures for the Insertion of Multiple Units of the Same Type of Medical Device for Calendar Years 2008 and 2009*". We appreciate the feedback your report provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

The audit covered $155,055 in Medicare outlier payments to hospitals for 45 claims for outpatient procedures that included the insertion of more than one of the same type of medical device. The 45 claims had dates of service during calendar years (CY) 2008 and 2009

Of the 45 claims reviewed, Medicare paid 32 correctly for outpatient services. Medicare did not pay the remaining 13 hospital claims correctly. These incorrect payments were due to hospitals overstating or understating the number of units and related charges. These errors resulted in excessive or unwarranted outlier payments for 12 claims and a reduced outlier payment for one claim, thus the following recommendations:

- **Recover the $40,678 in net overpayments for 13 inaccurate claims.**

  Palmetto GBA Response:
  All claims identified in the audit are adjusted and completed as of September 2010.

- **Continue to alert hospitals of the importance of coding outpatient claims with the correct number of medical device units.**

  Palmetto GBA Response:

  - Our recent CERT/Claim Submission Errors One-on-One sessions focused on documentation and improper payments.
  - Our Provider Outreach and Education (POE) Tour for 2011 continues to focus on our largest specialties (Inpatient Hospitals and Skilled Nursing Facilities) which historically contribute to the top errors.

- Additional 2011 and 2012 provider outreach and education events will include seminars and workshops on:
  - Claims Submission Errors
  - Billing and Coding
  - Part B Small and New Provider Billing Training
  - CERT
  - Top Denials and Inquiries.

  Palmetto GBA will address claims submission errors on a quarterly basis in our ACTs (what is ACTs?) and monthly meetings with hospital Compliance Officers to increase awareness.

- **Work with CMS to strengthen FISS prepayment edits by revising the unit amount thresholds for certain medical devices.**

Palmetto GBA Response:

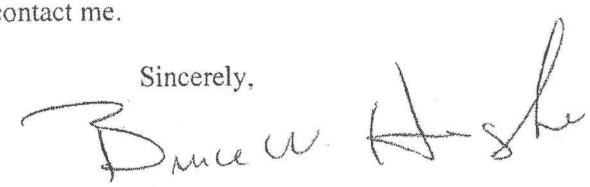
Palmetto GBA has implemented Medically Unlikely Edits (MUEs), Maximum Allowed Units (MAUs), and exclusion edits (e.g. dental, cosmetic). Correct coding has been and continues to be discussed in each educational session.

The link with the full explanation of the edits is listed below.

http://www.cms.gov/NationalCorrectCodInitEd/08_MUE.asp

Thank you for providing Palmetto GBA with the opportunity to comment on your report. If you have any questions, please do not hesitate to contact me.

Sincerely,



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