DEPARTMENT OF HEALTH & HUMAN SERVICES **OFFICE OF INSPECTOR GENERAL**

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

October 5, 2011

Report Number: A-03-11-00006

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 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-03-11-00006 in all correspondence.

Sincerely,

/Stephen Virbitsky/
Regional Inspector General
for Audit Services

Enclosure

cc: Neal Burkhead, Vice President, J11 AB MAC Operations
Yvonna Ruff, Director, Part A Claims

Direct Reply to HHS Action Official:

Ms. 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, MO 64106

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 PALMETTO GBA, LLC, IN JURISDICTION 11 FOR THE PERIOD JANUARY 1, 2006, THROUGH JUNE 30, 2009

Daniel R. Levinson
Inspector General

October 2011
A-03-11-00006

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.

During our audit period, Palmetto GBA, LLC, (Palmetto), was the Medicare fiscal intermediary for North Carolina and South Carolina. From January 2006 through June 2009, Palmetto processed approximately 122 million line items, of which 1,048 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.")

On May 21, 2010, CMS announced that 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.

OBJECTIVE

Our objective was to determine whether Medicare payments exceeding the line billed charge amount by $500 to $1,000, which Palmetto made to providers for outpatient services, were correct.

SUMMARY OF FINDINGS

Of the 1,048 selected line items for which Palmetto made Medicare payments to providers for outpatient services during our audit period, 338 were correct. Providers refunded overpayments on 91 line items totaling $85,256 before our fieldwork. The remaining 619 line items were incorrect and included overpayments totaling $744,416 that the providers had not refunded by the beginning of our audit.

Of the 619 incorrect line items:

- Providers reported incorrect units of service on 452 line items, resulting in overpayments totaling $523,809.
- Providers did not provide supporting documentation for 61 line items, resulting in overpayments totaling $69,728.
- One provider billed for the unlabeled use of a drug/biological on 21 line items, resulting in overpayments totaling $57,035.
- Providers billed separately for services on 39 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling $44,136.
- Providers used incorrect HCPCS codes on 19 line items, resulting in overpayments totaling $20,526.
- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 20 line items, resulting in overpayments totaling $16,590.
- Providers billed for unallowable services or drugs on seven line items, resulting in overpayments totaling $12,592.

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. Palmetto 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 $744,416 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.

Palmetto GBA, LLC

During our audit period, Palmetto GBA, LLC (Palmetto), was the Medicare fiscal intermediary for North Carolina and South Carolina. From January 2006 through June 2009, Palmetto processed approximately 122 million line items for outpatient services in North Carolina and South Carolina. On May 21, 2010, CMS announced that 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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Medicare payments exceeding the line billed charge amount by $500 to $1,000, which Palmetto made to providers for outpatient services, were correct.

Scope

Of the approximately 122 million line items for outpatient services that Palmetto processed during the period January 2006 through June 2009, 1,048 line items had (1) a Medicare line payment amount exceeding the line billed charge amount by $500 to $1,000 and (2) 3 or more units of service.[3]

We limited our review of Palmetto'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-03-10-00006.

Our fieldwork included contacting Palmetto in Columbia, South Carolina, and the 124 providers in North Carolina and South Carolina that received the selected Medicare payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[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."

- 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 1,048 line items, totaling $1,540,145, that Medicare paid to 124 providers;

- contacted the 124 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 Palmetto; and

- discussed the results of our review with Palmetto on February 28, 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 1,048 selected line items for which Palmetto made Medicare payments to providers for outpatient services during our audit period, 338 were correct. Providers refunded overpayments on 91 line items totaling $85,256 before our fieldwork. The remaining 619 line items were incorrect and included overpayments totaling $744,416 that the providers had not refunded by the beginning of our audit.

Of the 619 incorrect line items:

- Providers reported incorrect units of service on 452 line items, resulting in overpayments totaling $523,809.

- Providers did not provide supporting documentation for 61 line items, resulting in overpayments totaling $69,728.

- One provider billed for the unlabeled use of a drug/biological on 21 line items, resulting in overpayments totaling $57,035.

- Providers billed separately for services on 39 line items for which payment was packaged in the payment for the primary service, resulting in overpayments totaling $44,136.

[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 used incorrect HCPCS codes on 19 line items, resulting in overpayments totaling $20,526.

- Providers reported a combination of incorrect units of service and incorrect HCPCS codes on 20 line items, resulting in overpayments totaling $16,590.

- Providers billed for unallowable services or drugs on seven line items, resulting in overpayments totaling $12,592.

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. Palmetto 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 452 line items, resulting in overpayments totaling $523,809. Primarily, these overpayments occurred for two reasons:

- Thirty-six providers billed Medicare for 338 line items with incorrect service units involving 31 different drugs, biologicals,[5] and blood products. Rather than billing between 1 and 350 service units, providers billed between 3 and 2,500 service units.

[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.

These errors occurred because of human error or because the provider's chargemaster[6] was incorrect. As a result of these errors, Palmetto paid the 36 providers a total of $445,687 when it should have paid $84,821, an overpayment of $360,866.

- Thirteen providers billed Medicare for 38 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 38 cases, the provider performed between 1 and 5 surgical procedures but billed for between 3 and 32 services. As a result of these errors, Palmetto paid the 13 providers a total of $132,179 when it should have paid $46,305, an overpayment of $85,874.

Unsupported Services

Eighteen providers billed Medicare for 61 line items for which the providers could not provide supporting documentation. The providers agreed to cancel the claims associated with these line items or file adjusted claims and refund the combined $69,728 in overpayments that they received.

Unlabeled Use of a Drug/Biological

One provider billed Medicare for the unlabeled use of the biological Retavase for 21 line items for 3 or 4 units, resulting in overpayments totaling $57,035. Retavase is approved by the Food and Drug Administration (FDA) to treat cardiac conditions using a single-use dose (18.1 mg). However, the provider split a single labeled dose into 25 separate "mini" doses and used each mini dose as a thrombolytic[7] agent to clean dialysis patient catheters. The provider then billed Medicare for a full single-use dose of Retavase for each mini dose administered. According to the *Medicare Benefit Policy Manual* (Pub. No. 100-02, chapter 15, section 50.4.2):

> An unlabeled use of a drug is a use that is not included as an indication on the drug's label as approved by the FDA. FDA approved drugs used for indications other than what is indicated on the official label may be covered under Medicare if the carrier determines the use to be medically accepted, taking into consideration the major drug compendia, authoritative medical literature and/or accepted standards of medical practice.… These decisions are made by the contractor on a case-by-case basis. [Emphasis added.]

Providers must identify on their claims that the billed service was for the unlabeled use of a drug or biological.[8] However, the provider submitted these line items as if three or four single-use doses were administered for the labeled use. Consequently, Palmetto did not know that the 21

[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.

[7] The *Medicare Claims Processing Manual*, Pub. No. 100-4, chapter 8, section 60.2.1.1, identifies "thrombolytics: used to declot central venous catheters" as a separately billable drug used to treat a patient's renal condition.

[8] Providers should indicate the unlabeled use of a drug or biological in the remarks section of the claim.

line items were for an unlabeled use that required a case-by-case payment determination and incorrectly paid the provider $57,035.

Payment for Packaged Services

Eight providers billed Medicare on 39 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 $44,136. For example, 2 providers billed Medicare for 26 line items for linezolid or bortezomib. During the dates of service that the provider administered these drugs, Medicare included payment for these drugs in the payment for the primary surgical procedure and did not provide for separate reimbursement under the prospective payment system. As a result of these errors, Palmetto incorrectly paid the provider $24,279.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used incorrect HCPCS and other bill-processing codes[9] for 19 line items, resulting in overpayments totaling $20,526. The following examples illustrate the use of incorrect HCPCS codes:

- One provider billed Medicare for 10 line items using an incorrect condition code. The condition code identified the procedure as "home dialysis training" (condition code 73) rather than "home dialysis" (condition code 74), the service actually performed. As a result of these errors, Palmetto paid the provider $14,766 when it should have paid $5,556, an overpayment of $9,210.

- One provider billed Medicare for 1 line item for 600 units of service of epoetin alfa. The provider billed Medicare using HCPCS code J0885 that is administered to patients without renal disease; rather, the provider should have billed Medicare using HCPCS code Q4081 that is administered to patients with renal disease.[10] As a result of this error, Palmetto paid the provider $4,370 when it should have paid $432, an overpayment of $3,938.

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 20 line items. These errors resulted in overpayments totaling $16,590. For example, one provider billed Medicare for 6 units of a 0.5-mg dose of rasburicase (HCPCS code J2783); however, the provider should have billed for 200 units of a 1-mg dose of iron sucrose (HCPCS code J1756). Similar errors occurred on a total of 13 line items that this provider submitted. As a result of these errors, Palmetto paid the provider $10,699 when it should have paid $812, an overpayment of $9,887.

[9] These bill-processing codes included condition codes, which indicate that a special condition applies to the bill and may affect processing and payment of the claim.

[10] While each unit of service for HCPCS code J0885 represents 1,000 units of epoetin alfa; each unit of service for HCPCS code Q4081 represents only 100 units of epoetin alfa.

Services Not Allowable for Medicare Reimbursement

Providers incorrectly billed Medicare for seven line items for which the services provided were not allowable for Medicare reimbursement, resulting in overpayments totaling $12,592. For example, three providers billed Medicare for five line items for dental procedures that were not covered outpatient services. 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. None of the five dental services billed was an integral part of another covered procedure. As a result of these errors, Palmetto incorrectly paid the provider $9,812.

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. Palmetto 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.[11]

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 $744,416 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.

[11] 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

Palmetto GBA℠
PARTNERS IN EXCELLENCE℠

Bruce W. Hughes
President and Chief Operating Officer

August 17, 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: Report No. A-03-11-00006

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 Palmetto GBA, LLC, in Jurisdiction 11 for the Period January 1, 2006 Through June 30, 2009*". 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 May 25, 2011. During the audit period approximately 1,048 outpatient line items were selected which had;

(1) a Medicare line payment amount that exceeded the line billed charge between $500 and $1,000
(2) an incorrect units of services
(3) a billing for unlabeled use of a drug/biological
(4) a billing separately for packaged services
(5) a use of incorrect HCPC codes
(6) a billing for unallowable services

Of the 1,048 selected line items for which Medicare payments to providers for outpatient services during the audit period, 338 were correct. Providers refunded overpayments on 91 line items totaling $85,256 before fieldwork. The remaining 619 line items were incorrect. Thus the following recommendations:

- **Recover the $744,416 identified overpayments.**

  Palmetto GBA Response:
  All claims identified in the audit are adjusted and completed as of May 26, 2011.

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

  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.
- In the Drugs and Biologicals Webinar providers are instructed to identify drugs and biologicals with appropriate HCPCS codes and the appropriate units.
- The 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.
- 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 include seminars and workshops on:
  - Claims Submission Errors
  - Billing and Coding
  - Part B 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 ACTs and monthly meetings with hospital Compliance Officers to increase awareness.

Thank you for providing Palmetto GBA with the opportunity to submit feedback regarding your review. If you have any questions, please do not hesitate to contact me.

Sincerely

/Bruce W. Hughes/

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