OFFICE OF INSPECTOR GENERAL

Audit Report

Audit of the Railroad Medicare Integrity Program at Palmetto Government Benefits Administrators

Report No. 09-04
September 25, 2009

RAILROAD RETIREMENT BOARD

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INTRODUCTION

This report presents the results of the Railroad Retirement Board (RRB), Office of Inspector General's (RRB-OIG) audit of the Railroad Medicare Integrity Program at Palmetto Government Benefits Administrators (Palmetto).

Background

The RRB is an independent agency in the executive branch of the Federal government. The RRB administers the retirement/survivor and unemployment/sickness insurance benefit programs for railroad workers and their families under the Railroad Retirement Act (RRA) and the Railroad Unemployment Insurance Act (RUIA). These programs provide income protection during old age and in the event of disability, death, temporary unemployment or sickness. The RRB paid approximately $10.2 billion in retirement/survivor and unemployment/sickness benefits to 628,000 beneficiaries during fiscal year (FY) 2008. The RRB is headquartered in Chicago, Illinois and has 53 field offices nationwide.

Railroad Medicare

The Centers for Medicare and Medicaid Services (CMS) have overall responsibility for the Medicare program. The RRB has statutory authority to contract with a separate Medicare carrier.[1] Since April 2000, the RRB has contracted with Palmetto to be the agency's nationwide Medicare Part B carrier. In this role, Palmetto is responsible for processing Medicare Part B claims for qualified Railroad Retirement beneficiaries. In fiscal year 2008, Railroad Medicare paid out approximately $844 million for Part B medical services. In connection with its separate carrier authority, the RRB is responsible for certain Medicare program activities such as enrollment, premium collection, answering beneficiary inquiries and conducting the annual carrier performance evaluation for the Medicare carrier. The RRB manages one nationwide contract with Palmetto for processing Medicare Part B claims for all railroad beneficiaries.

The Inspector General Act of 1978, as amended, authorizes the RRB-OIG to conduct oversight activities, such as audits and investigations, for all programs and operations conducted by the RRB. Beginning in fiscal year 1997, an appropriations law restriction prohibited the RRB-OIG from conducting Railroad Medicare oversight. In December 2007, President Bush signed P.L 110-161 which restored the RRB-OIG's oversight authority for Railroad Medicare.

[1] Sec. 1842(g) [42 U.S.C. 1395u] of the Social Security Act

Medicare Integrity Program

The CMS is responsible for ensuring that charges are paid only for reasonable and necessary Medicare services. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 created the Medicare Integrity Program (MIP) which consists of medical review, cost report audit, data analysis, provider education, and fraud detection and prevention. The MIP was established, in part, to strengthen CMS' ability to deter fraud and abuse in the Medicare program.

CMS follows four parallel strategies in meeting this goal: 1) preventing fraud through effective enrollment and through education of providers and beneficiaries; 2) early detection through, for example, medical review and data analysis; 3) close coordination with partners, including contractors and law enforcement agencies; and 4) fair and firm enforcement policies.

CMS established regional Program Safeguard Contractors (PSCs) to perform specific MIP functions under contract including:

- Fraud case development
- Fraud complaint processing
- Provider education
- Pre-payment and post-payment medical review
- Data analysis
- Law enforcement support

The primary goal of program integrity is to pay claims correctly and protect the Medicare Trust Fund from fraud, waste and abuse.[2] In order to meet this goal, contractors must ensure that they pay the right amount for covered and correctly coded services rendered to eligible beneficiaries by legitimate providers.

Contract Responsibilities

The RRB's contract with Palmetto states that, "The contractor shall perform all carrier functions for individuals enrolled in Part B of the Railroad Medicare program throughout the United States." Railroad Medicare claims are submitted by providers who are located in multiple regions. The RRB does not contract with a regional PSC and Palmetto retains all responsibility for MIP activities.

Maintaining benefit integrity is one of Palmetto's MIP responsibilities under its cost reimbursement contract with the RRB. The primary goal of this function is to identify and fully develop cases of suspected fraud in a timely manner. Immediate action is necessary to ensure that Medicare Trust Fund monies are not inappropriately paid out and that any mistaken payments are recovered.

[2] During 2009, Medicare spending will account for almost 20 percent of the federal budget and 3.2 percent of gross domestic product (GDP).

Suspension and denial of payments and the recoupment of overpayments are an example of the actions that may be taken. All cases of potential fraud are to be referred to the RRB-OIG's Office of Investigations for consideration and initiation of criminal or civil prosecution, civil monetary penalty, or administrative sanction actions. Palmetto's Benefit Integrity (BI) unit works directly with the RRB-OIG's Office of Investigations to achieve this goal.

Within the Program Support Division, the RRB's Medicare Contractor Operations Specialists (MCOSs) provide contract oversight and act as communication liaisons with Palmetto. The MCOSs performed five reviews of Palmetto's operations during FY 2008.

Program Guidance

As referenced in the Medicare Part B Budget and Performance Requirements, contractor budget requests should ensure implementation of all program requirements in the Program Integrity Manual (PIM) and all applicable transmittals. Medicare contractors shall follow the PIM to the extent outlined in their respective statements of work. The PIM supports the Government Performance Results Act which requires contractors to reduce the error rates identified in the Chief Financial Officer's audit and Comprehensive Error Rate Testing program.

The RRB's strategic plan prescribes effectiveness, efficiency and security of operations as objectives within the agency's larger goal of serving as responsible stewards of the trust funds and financial resources under agency control. This audit supports those objectives.

Audit Objective

The objective of our audit was to identify areas for improvement in the MIP implemented by Palmetto.

Scope

The scope of our audit was MIP activities during FY 2008.

Methodology

To accomplish our objective, we:

- identified and reviewed the laws and regulations applicable to Railroad Medicare;
- interviewed Palmetto and RRB officials responsible for Railroad Medicare;

- reviewed and compared Railroad Medicare contract terms and CMS requirements;
- analyzed Palmetto's claims error rate methodology and compared it with CMS' Comprehensive Error Rate Testing methodology;
- reviewed high dollar overpayment receivables;
- examined complaint and case records within the Fraud and Abuse Case Tracking System (FACTS) database;
- tested and reconciled balances contained in select line items that comprise total expense for benefit integrity;
- obtained an understanding of the Palmetto cost accounting system, reviewed select cost accounting transactions, and traced their support;
- identified functional activities performed by the Railroad Medicare BI unit fraud investigator; Medical Review unit and other program integrity functions;
- compared Palmetto's benefit integrity procedures with PIM guidance;
- reviewed amounts budgeted and actual costs for benefit integrity activities;
- assessed the activities performed by the RRB's Medicare Contractor Operations Specialists; and
- evaluated provider outreach and education activities addressing benefit integrity.

The foregoing audit procedures were applied to FY 2008 activities. Reference was also made to prior year data for comparative purposes.

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 objectives.

We conducted our audit fieldwork at Palmetto's Medicare offices located in Augusta, Georgia and at the RRB's Headquarters in Chicago, Illinois from December 2008 through May 2009.

RESULTS OF AUDIT

More could be done to identify fraud and abuse in the Railroad Medicare program by strengthening its Railroad Medicare BI unit. During FY 2008 Railroad Medicare paid $844 million with an estimated exposure to improper payments of about $31 million based on national averages.[3] By comparison, Palmetto reported MIP savings of $6.3 million of which 89% was attributable to coordination of benefits with other healthcare plans, 10% was attributed to medical review of claims and 1%, or about $40,000 resulted from proactive benefit integrity activities to identify fraud and abuse.

Our audit disclosed that the Railroad Medicare BI unit has very limited resources with which to perform proactive fraud investigations and data analysis because the unit is staffed with only a single full-time employee to perform all required BI functions. During FY 2008, about two-thirds of the units' $225,000 in expenditures were absorbed by indirect costs which are budgeted and reported without sufficient detail to support an effective budget process.

We observed that Railroad Medicare does not develop estimates of improper payments using the method used by CMS for other Medicare contractors nationwide. As a result, Palmetto cannot adequately measure Railroad Medicare's potential exposure to errors and improper payments.

In addition, Railroad Medicare BI could be more effective in identifying, researching and referring potential fraud in the following areas:

- identification of providers excluded from the Medicare program;
- investigation of claims submitted by excluded providers;
- referral of high-dollar payments and claims for investigation; and
- fraud training for BI staff.

During our audit, we also concluded that Railroad Medicare's benefit integrity procedures should be more complete and that agency oversight could be strengthened through a longer-term formal planning process. We believe that compliance could be enhanced by closer adherence to requirements for prioritizing information requests for information and by requesting a waiver of the Medicare Director requirement. Finally, we suggest that BI unit personnel might benefit from periodic reports on the collection status of cases it initiates.

The details of our findings and recommendations for corrective action follow.

[3] This estimate uses the most recent available error rate (3.7% for FY 2007) applied to the FY 2008 payment total.

Proactive Fraud Investigations and Data Analyses Are Limited

Palmetto's BI unit has performed only a limited number of proactive fraud investigations and data analyses. Proactive efforts originate in the BI unit and are not the result of referrals/requests from other organizations.

Contractors should ensure implementation of all program requirements outlined in the PIM. The PIM establishes the functional responsibilities to be carried out by the BI unit. The BI unit is responsible for preventing, detecting, and deterring Medicare fraud. The BI unit:

- prevents fraud by identifying program vulnerabilities; and
- proactively identifies incidents of potential fraud that exist within its service area and takes appropriate action on each case.

BI units are required to use a variety of techniques, both proactive and reactive, to address any potentially fraudulent provider billing practices.[4]

During our audit, we observed that Palmetto's BI unit had proactively initiated only one provider investigation during FY 2008. Its fraud database (FACTS) referenced only six proactive complaints during the past eight years (three during 2001, two during 2002, and one during 2004). Palmetto officials stated that they do not conduct investigative reviews at offsite provider locations.

Palmetto's BI unit has not established a proactive fraud-based work plan and Palmetto management believes the BI unit is understaffed because it has only one investigator assigned to conduct all CMS PIM requirements. Presented below is a recap of the disposition of the BI unit's budget for FY 2008.

BENEFIT INTEGRITY UNIT EXPENDITURES FY 2008		
Labor Costs	$62,324	28%
Direct Non-Labor Costs	13,823	6%
	========	
Direct Costs of the BI Unit	$76,147	34%
Pension & 401 K Costs	$18,445	8%
Data Analysis	36,061	16%
Other Allocated Indirect Cost	57,850	26%
General & Administrative Expense	36,239	16%
	========	
Indirect Costs	$148,595	66%
Total BI Unit Expenditures	$224,742	100%

[4] Chapter 4.2.2 of the PIM

We observe that the low investment in direct labor is consistent with BI management's description of their staffing levels. In addition, about two-thirds of the relatively small BI unit budget is absorbed by indirect costs, including over $36,000 of indirect costs allocated from Palmetto and its parent company, Blue Cross Blue Shield of South Carolina.

If proactive fraud investigations and data analyses are not formally planned, thoroughly developed and regularly performed, improper Railroad Medicare payments may go undetected.

Recommendation

We recommend that Palmetto officials:

1. work with CMS and RRB officials to obtain the budget and staff resources needed to conduct the proactive fraud investigation and data analysis responsibilities outlined in the PIM.

Management's Response

Palmetto officials supported our recommendation and agreed with RRB officials that necessary funding should be pursued to conduct the proactive fraud investigation and data analysis responsibilities outlined in the PIM. The full text of Palmetto's response is included as Appendix IV to this report.

Additional Budget and Accounting Detail Is Needed

Budget planning, monitoring, and reporting are not adequately detailed to support an effective benefit integrity program for Railroad Medicare. Although Palmetto's cost accounting system captures time and program cost data, the system doesn't capture sufficient detail about its benefit integrity efforts to support informed decision-making.

Palmetto must track costs in accordance with CMS requirements. CMS currently provides only a single activity code to capture time and cost data for all of Palmetto's Railroad Medicare benefit integrity activities. During our audit, we observed that prior to FY 2007, CMS' CAFM II[5] guidance provided eight different codes for the various responsibilities that comprise benefit integrity.

- Medicare Fraud Information Specialist
- Fraud Complaint Development
- Outreach and Training

[5] Contractor Administrative Budget and Financial Management System II (CAFM II) supports the national budget of Medicare contractors and is used to administer and monitor Medicare program payments and report the results of program expenditures.

- Fraud Case Development
- Law Enforcement Support
- Medical Review Support of Benefit Integrity Activity
- Fraud Investigation Data
- Referrals to Law Enforcement

Effective for FY 2007, these eight codes were replaced with a single code. CAFM II guidance for this activity code states that, "[t]he RRB must include costs for BI outreach and training, potential fraud investigations, case referrals, law enforcement support, medical review in support of BI, and FID entries in this Activity Code."[6]

During our audit, we observed that the use of a single activity code would hamper efforts to hold informed discussions about funding levels and contractor accomplishments in this area. This effect carries over to the budget process which no longer includes details about the extent to which the budget will fund all areas of benefit integrity responsibility which is detrimental to a transparent budget process. A transparent budget process is critical to ensure that Railroad Medicare's investment in benefit integrity activities will be effective in addressing fraud, waste and abuse.

Recommendation

We recommend that RRB officials:

2. request that Palmetto officials identify and monitor the specific benefit integrity cost components either through revised CAFM II activity reporting or independently of the CAFM II process.

Management's Response

RRB officials agreed with our recommendation and will request the funding to perform the monitoring starting with the new contract period. The full text of the RRB's response is included as Appendix III to this report.

CERT Methodology Would Strengthen Improper Payment Estimates

The Railroad Medicare program has not been assessed by the CMS Comprehensive Error Rate Testing (CERT) program. Consequently, Railroad Medicare's claims processing error rate and improper payments workload estimates cannot be compared with the rates and workloads of other Medicare carriers which are computed under the CERT methodology.

[6] FY 2008 Budget and Performance Requirements, Medicare Integrity Program, pgs. 11-12

As described in its methodology, CMS calculates the Medicare Fee-For-Service error rate and estimate of improper claim payments using a methodology approved by the Department of Health & Human Services, Office of Inspector General (HHS-OIG). The CERT methodology includes:

- randomly selecting a sample of approximately 120,000 submitted claims;
- requesting medical records from providers who submitted the claims; and
- reviewing the claims and medical records for compliance with Medicare coverage, coding and billing rules.[7]

According to the PIM, "[t]he contractor shall use their CERT findings as the primary source of data to base further data analysis in identifying program vulnerabilities."[8]

CMS' CERT program determines carrier error rates through a statistical process that includes onsite validation of provider claim's supporting medical records at each participating carrier. In contrast, Palmetto periodically estimates the Railroad Medicare error rate by using an alternate methodology that does not include validation of supporting documentation. Therefore, the Palmetto computed error rates do not reflect claims rejected for insufficient medical records. A lack of medical records can also be an indicator of potential fraud.

CMS computes Medicare error rates for participating carriers on an individual basis and collectively determines a national error rate. Since Palmetto processes multi-state Railroad Part B claims nationally rather than regionally, we expect to find a correlation between the national error rate and the Railroad Medicare error rate.

Based on CMS' computed CERT national error rates, we estimate that Railroad Medicare's exposure to improper payments between 1997 and 2007 was $591 million.[9] This estimate is presented only for the purpose of demonstrating the broad exposure of Railroad Medicare to fraud and abuse and the importance of using a widely accepted error estimation methodology in justifying budgetary investments for loss prevention. As discussed in this report, Palmetto currently has only one BI unit investigator assigned to handle this workload and performs a very limited number of proactive fraud investigations.

[7] In 2006, the Government Accountability Office found the CERT methodology to be adequate for estimation (GAO-06-300).
[8] Chapter 1.2.3 of the PIM
[9] During this period, the RRB-OIG did not have oversight authority for Railroad Medicare. See Appendix I: "Estimated Improper Railroad Medicare Payments" for the source of this estimate.

CMS has not required Railroad Medicare to participate in its CERT program.[10] Palmetto officials do not believe Railroad Medicare needs to be included in the CERT process. Due to the national scope of the program, Palmetto management believes that Railroad Medicare providers would be sampled in the CERT testing of other carriers.

Because Railroad Medicare is not participating in the CERT program, Palmetto cannot adequately measure and report Railroad Medicare's exposure to errors and improper payments. In addition, Palmetto's performance cannot be compared to that of other carriers. In determining its current and historical claims error rate and volume of improper payments, Palmetto relies on its own quality assurance error rate estimates which are not comparable to the CERT methodology used for the rest of the Medicare program.

Without a recognized method of estimating exposure to improper payments, Palmetto management cannot be fully effective in recommending funding levels for benefit integrity investment. Overall, the effectiveness of Palmetto's Railroad Medicare MIP, which includes the BI unit, is diminished.

Recommendations

We recommend that RRB officials:

3. petition CMS to become an active participant in the CERT program;
4. determine the CERT compliant error rate applicable to its Part B workload; and
5. request funding to support a benefit integrity program commensurate with Railroad Medicare's exposure to improper payments as estimated using CERT methodology.

Management's Response

RRB officials agreed with our recommendations and will submit the request along with the budget request for FY 2010. These officials also indicated that the formation of a Railroad Specialty MAC in coordination with CMS would address and provide for these functions and program safeguards. The full text of the RRB's response is included as Appendix III to this report.

[10] Palmetto's Railroad Medicare operations are identified as CMS Carrier #882

Identification of Excluded Providers is Not Fully Effective

The Provider Enrollment unit is not using all available resources to identify providers who should be excluded from the Medicare program.

The PIM requires carriers to exclude parties barred by the General Services Administration (GSA) from receiving Federal contracts.[11] An excluded individual or entity that submits a claim for reimbursement to a Federal health care program, or causes such a claim to be submitted, may be subject to a Civil Monetary Penalty of $10,000 for each item or service furnished during the period that the person or entity was excluded.[12]

During our audit, we observed that although the Provider Enrollment unit screens prospective healthcare providers against the HHS-OIG's List of Excluded Individuals/Entities (LEIE), they do not employ GSA's Excluded Parties List System (EPLS). EPLS identifies individuals and organizations who have been excluded from Federal procurement and non-procurement programs as well as certain other individuals and organizations identified for sanction by the Department of Treasury, such as drug traffickers and terrorists.

Our review disclosed that enrollment unit procedures did not include any reference to the EPLS. We inquired further about this matter in a follow-up discussion which did not reveal any additional information concerning why EPLS was not in use.

If all available resources are not used, excluded parties may be enrolled in Railroad Medicare and receive payments to which they are not entitled.

Recommendation

We recommend that Palmetto officials:

6. revise its sanction monitoring procedure to ensure that the Provider Enrollment unit performs a reconciliation with the EPLS.

Management's Response

Palmetto management responded that, per CMS instructions, Railroad Medicare does not process 855 enrollment forms and that the criteria cited in the draft audit report was specific to the processing of that form. Railroad Medicare enrolls only those providers who have already been credentialed and enrolled by other carriers to whom Form 855 had been submitted. The full text of Palmetto's response is included as Appendix IV to this report.

[11] PIM Chapter 10, Section 1.3; Chapter 4, Section 4.19.4.1
[12] Section 1128A(a)(1)(D) of the Social Security Act

RRB OIG's Comments on Management's Response

We do not disagree that PIM Chapter 10, Section 1.3 limits prescreening responsibility to those charged with processing Form 855. However, we note that contractors have ongoing responsibility to ensure that sanctioned providers are not being inappropriately paid. PIM Chapter 4, Section 4.19.4.1 discusses this responsibility and we have added this reference to the related report footnote. To meet this responsibility, Palmetto management states that "all existing providers are checked monthly against the LEIE," with no mention of EPLS.

Requirements of the PIM not withstanding, EPLS is an important resource for the identification of providers who should be excluded from the Medicare Program. We stand by our observation that Palmetto is not using all available resources to identify providers who should be excluded because Railroad Medicare procedures do not reference EPLS and responsible staff were not knowledgeable about this resource.

Excluded Provider Investigations Could Identify Improper Payments

When Palmetto identifies a provider that has been excluded from the Medicare program, Railroad Medicare suspends future payments to that provider. However, the BI unit does not identify and investigate claims paid prior to that suspension.

According to the PIM, "[i]f the contractor or PSC believes there are past periods of time that may contain possible overpayments, contractors and PSCs shall consider recommending a new suspension of payment covering those dates."[13] The PIM further states that the BI unit, "[i]nitiates appropriate administrative actions to deny or to suspend payments that should not be made to providers where there is reliable evidence of fraud."[14]

During our audit we observed that 446 (14%) of the 3,129 providers listed in the LEIE as excluded from the program during FY 2008 were enrolled in Railroad Medicare. These providers may have submitted fraudulent or improper claims prior to their exclusion. The BI unit has not determined how many potential overpayments were made to these providers prior to their exclusion date.

Current Railroad Medicare procedures do not provide for investigation of claims submitted prior to exclusion.

[13] Chapter 3.9.2.7 of the PIM
[14] Chapter 4.2.2 of the PIM

Providers are excluded from the Medicare program for cause. Exclusion is an indicator that the provider may have submitted fraudulent or otherwise improper claims for payment in the past. Railroad Medicare cannot recoup overpayments unless such claims are identified, evaluated and investigated by the carrier.

Recommendation

We recommend that Palmetto officials:

7. establish BI unit procedures for investigating payments submitted by excluded providers prior to their exclusion date and refer claims to the RRB-OIG's Office of Investigations for further investigation as appropriate.

Management's Response

Palmetto officials indicated that they have created a procedure to perform data analysis on claims prior to the exclusion date. The data analysis will include all claims dated back 5 years from the date of exclusion. The claims and any other relevant information will be reviewed for fraudulent activity. The full text of Palmetto's response is included as Appendix IV to this report.

High Dollar Transactions Should Be Referred For Investigation

Palmetto does not refer its high dollar receivables and payments to the RRB-OIG's Office of Investigations for fraud evaluation.

The CMS Carriers Manual requires carriers to effectively and continually analyze data that identifies aberrancies, emerging trends and areas of potential abuse, over utilization or inappropriate care, and focus on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes.[15]

HHS-OIG considers claims for payment of $10,000 or more to be at high risk for overpayment through error or fraud. In addition, the RRB-OIG can evaluate the circumstances of an identified overpayment to determine whether fraud was involved.

During our audit we identified nine provider receivables recorded during FY 2008 greater than $10,000 which could have been referred to the RRB-OIG's Office of Investigations, but were not.

[15] Section 5261.3

Palmetto has not established a procedure for flagging and referring its high dollar payments and receivables to the RRB-OIG's Office of Investigations for further investigation. If high dollar transactions are not referred to the RRB-OIG's Office of Investigations, provider fraud may go undetected.

As result, fraud in the Railroad Medicare program may not be identified timely.

Recommendation

We recommend that Palmetto officials:

8. coordinate the referral of high dollar payments and receivables, those in excess of $10,000, with the RRB-OIG's Office of Investigations.

Management's Response

Palmetto officials agreed with our recommendation and will provide the BI unit with a monthly RRB accounts receivable report. Any overpayments over $10,000 will be referred to the BI unit investigator and the RRB OIG. The full text of Palmetto's response is included as Appendix IV to this report.

Investment in Fraud Training is Needed

Palmetto's BI unit investigator is not receiving periodic fraud training. The primary investigator is the focal point for the development and performance of proactive fraud initiatives and statistical data analysis work plans.

The PIM requires that BI unit staff be adequately qualified for the work of detecting and investigating situations of potential fraud and that each BI unit send the appropriate representative(s) to CMS' national benefit integrity training each year it is provided. Additionally, all levels of employees shall know the goals and techniques of fraud detection and control in general and as they relate to their own areas of responsibility (i.e., general orientation for new employees and highly technical sessions for BI unit staff and if applicable, medical review staff).[16]

The RRB's contract with Palmetto for Medicare Part B Services requires minimum training of 16 hours per year on fraud detection techniques/data analysis and 4 hours of interviewing techniques.[17]

[16] Chapter 4.2.2.3 of the PIM
[17] RRB Contract No. 00RRB005 (Attachment B)

During our audit, we observed that this investigator had not received training since accepting the position in July 2007. Palmetto has not enforced staff compliance with the CMS PIM and RRB contract training requirements. Palmetto officials indicated that funding had not been available for training.

If Palmetto staff that are responsible for benefit integrity investigative work do not receive adequate refresher training in fraud related subjects, potential fraudulent scenarios or improper payments may go undetected.

Recommendation

We recommend that Palmetto officials:

9. request specific funding for fraud related training and actively monitor staff compliance with the CMS' PIM and the RRB contract's benefit integrity training requirements.

Management's Response

Palmetto officials did not agree with our recommendation and indicated that its program support staff receives technical based training at least annually while each RRB contract associate periodically receives a minimum of 15 minutes of fraud awareness training for a total of 50 hours annually. The BI unit investigator is currently obtaining Certified Fraud Examiner status. The full text of Palmetto's response is included as Appendix IV to this report.

RRB OIG's Comments on Management's Response

Our audit recommendation addressed specialized training in the areas of fraud detection, data analysis and interviewing techniques as required by CMS and the RRB's contract terms. Our fieldwork determined that BI unit staff had not received this form of training. While achievement of Certified Fraud Examiner status is a positive step, periodic specialized fraud training is required.

Benefit Integrity Procedures Can Be Improved

Palmetto's benefit integrity procedures do not address all PIM requirements.

According to the PIM, "[c]ontractors shall provide written procedures for personnel in various contractor components (claims processing, MR[18], beneficiary services, POE[19], intermediary audit, etc.) to help identify potential fraud situations."[20]

[18] Medical Review
[19] Provider Outreach and Education
[20] Chapter 4.2.2.4 of the PIM

During our audit, we observed that the BI unit had not established procedures for:

- Initiating and conducting the investigation and recoupment of prior overpayments to excluded providers. Potentially fraudulent claims prior to the date of exclusion are not investigated.
- Referring high dollar accounts receivable to RRB-OIG's Office of Investigations for investigative review.
- Reimbursement when the beneficiary has paid a provider for services and the provider has received payment.
- Assisting a beneficiary when referred to a collection agency by a provider.
- Requests for beneficiary and provider information from outside organizations including disclosure requirements.
- Requests from RRB-OIG's Office of Investigations for data and other records including timeframes for responding to priority requests.
- Fraud Investigation Database (FID) complaint and recovery data entry and maintenance including time frames, classification and sensitivity.

The BI unit had not developed policies and procedures that fully addressed all of its PIM functional requirements. Without these procedures, BI unit staff will not have access to the reference information required to address its program requirements and conduct specific operational tasks in an efficient and timely manner.

Additional details regarding these procedural deficiencies are included in Appendix II.

Recommendation

We recommend that Palmetto officials:

10. correct the identified BI unit procedural deficiencies and ensure that procedures have been developed to address all CMS PIM requirements.

Management's Response

Palmetto officials agreed with our recommendation and advised that procedures were established as of August 13, 2008. As noted while the auditors were on-site, some of the procedures listed in the audit report had established procedures and were provided at the time of review. These officials also indicated that an ISO 9000 audit of the BI unit completed on July 28, 2009 resulted in no deficiencies and met CMS control objectives. The full text of Palmetto's response is included as Appendix IV to this report.

RRB OIG's Comments on Management's Response

In some cases, the procedures provided for our review did not adequately address the CMS PIM requirements.

RRB Oversight of Contractor Operations Should Be Strengthened

The RRB has not established a timeframe for conducting recurring reviews of Palmetto's MIP[21] components, including the BI unit. These reviews are part of the RRB's overall responsibility for contractor oversight.

Under the current contract, the RRB conducts evaluations of Palmetto's Railroad Medicare performance. During our audit, we observed that the most recent reviews of the BI unit were conducted by the RRB's MCOSs[22] about four years ago, in May and June of 2005.

The MCOS' reviews of program integrity are scheduled at the beginning of the year based on available resources. The reviews performed each year are rotated among the several MIP components which include the BI unit; however, the RRB has not established a formal planning process for determining the frequency with which these components will be evaluated.

Absent a formal planning process and management expectation concerning program coverage, RRB officials may not have the information they need to provide adequate stewardship.

Recommendation

We recommend that RRB officials:

11. work with the Program Support Division to establish a long-range planning process for conducting recurring reviews of Palmetto's MIP components.

Management's Response

RRB officials agreed with our recommendation and will establish a long-range planning process for conducting MIP reviews. The full text of the RRB's response is included as Appendix III to this report.

[21] Medicare Integrity Program
[22] MCOSs refers to the RRB's Medicare Contractor Operations Specialists

Prioritization of Information Requests Could Be Improved

Palmetto's BI unit did not prioritize and complete information requests in accordance with CMS' timeliness standards.

The BI unit is responsible for providing information to support the investigation of Medicare fraud, including the efforts of the RRB-OIG's Office of Investigations. The PIM requires that Priority I requests be fulfilled within thirty (30) days when the information or material is contained in the BI unit's files. BI units shall respond to less critical Priority II requests within 45 calendar days or if that timeframe cannot be met, the BI unit shall notify the requesting office within the 45-day timeframe, and include an estimate of when all requested information will be supplied.[23]

Palmetto officials advised that the BI unit attempts to respond to RRB-OIG requests in a reasonable time, attempting to complete their action within 30 days, and prioritizes cases by marking them as "rush." However, the BI unit's control spreadsheet detailing its handling of law enforcement requests did not identify the type of request and did not indicate which requests were categorized as "rush."

Although the BI unit does not prioritize this workload in accordance with the PIM, approximately 91% of all responses in calendar year 2008 were timely because they were completed within 30 days.

Number of Requests	Processing Time	% Down
2	65 days	3%
1	63 days	2%
1	57 days	2%
1	37 days	2%
51	<=30 days	91%
====		=====
56		100%

The Railroad Medicare BI unit is not fully compliant with PIM requirements for prioritization. As a result, the effectiveness of performance in this area cannot be fully measured because the requests were not initially identified as Priority I and Priority II. In addition, the unit may not be prepared to prioritize and respond within PIM requirements should the workload increase. Prioritization is critical to a process that is already constrained by limited staff. We note again that the BI unit has one full-time investigator, the only staff dedicated to BI activities.

[23] Chapter 4.4.1(G) of the PIM

Recommendation

We recommend that Palmetto officials:

12. classify RRB-OIG's Office of Investigations referrals and other BI unit information requests as Priority I or Priority II and monitor the timeliness of its responses to ensure compliance with PIM requirements.

Management's Response

Palmetto officials advised that they have established procedures addressing Priority I and Priority II requests. The full text of Palmetto's response is included as Appendix IV to this report.

Waiver of Medical Director Should Be Requested

Palmetto does not employ a dedicated medical director for Railroad Medicare and has not obtained a waiver of that PIM requirement from CMS. In addition to other responsibilities, the medical director serves as benefit integrity advisor.

The PIM requires that, "[c]ontractors who perform medical review must employ a minimum of one FTE [full-time equivalent] contractor medical director (CMD) and arrange for an alternate when the CMD is unavailable for extended periods. Waivers for very small contractors may be approved by the CO."[24] [25]

Palmetto officials stated that the Medical Director for Railroad Medicare was eliminated prior to implementation of the CMS waiver requirement. Palmetto officials believe they did not need to request a waiver but never solicited an approval from CMS. These officials also noted that inquiries can be directed to other, non-Railroad, Medicare medical directors to support independent medical decisions by clinicians; however no formal procedure has been established.

Absent a formal waiver, Palmetto may not be fully complaint with current PIM requirements.

[24] CO refers to CMS Central Office.
[25] Chapter 1.4 of the PIM

Recommendation

We recommend that Palmetto officials:

13. formalize their assessment that no Medical Director is necessary and request that CMS waive the PIM requirement; and
14. establish formal procedures for the Railroad Medicare program to obtain the services of other Medical Directors as necessary.

Management's Response

Palmetto officials agreed with our recommendations and will request a Medical Director waiver from the RRB. These officials also advised that the CMD position had been eliminated by the previous contractor and had not been required by the RRB in its contract with Palmetto. Procedures will also be established for obtaining professional Medical Director support services when the need arises. The full text of Palmetto's response is included as Appendix IV to this report.

RRB OIG's Comments on Management's Response

We clarify that according to the PIM, the waiver must be approved by CMS.

Internal Reporting of Overpayment Recoveries Could Assist Operations

The Railroad Medicare BI unit does not receive notification when refunds are received or periodic reports on the status of collections because current procedure does not require it.

The BI unit's procedure directs closure of a case when, "[e]vidence of improper practices was identified and the case was either referred to law enforcement and denied or handled administratively and all administrative actions have been completed."[26]

The BI unit does not receive information confirming overpayment recoveries received from providers. This information is available on a request basis but no periodic or annual report is produced and the BI unit does not presently request this information.

Without confirmation of monetary recoveries, the BI unit cannot monitor its operational progress and effectiveness or consider collection experience in determining how to expend the BI unit's scarce personnel resources.

[26] Palmetto Case Closure Instruction, pg. 1

Recommendation

We recommend that Palmetto officials:

15. request that periodic reports be provided to the BI unit detailing the status of BI collections on a case-by-case basis.

Management's Response

Palmetto officials agreed with our recommendation and advised that a detailed report of any collections that have occurred will be provided by the Finance unit on request. The full text of Palmetto's response is included as Appendix IV to this report.

Railroad Medicare Program
Estimated Improper Payment Levels

The following table summarizes the RRB-OIG's estimate of the improper Railroad Medicare payments occurring by year during the period when RRB-OIG was prohibited from conducting Railroad Medicare oversight.

Improper payment estimates were computed by applying CERT National Error Rates based on prior year claims to prior year Railroad Medicare Payments. The CERT National Error Rate applicable to 2008 claims was not available prior to the issuance of this report.

This estimate includes payments by Palmetto GBA (Carrier #882) and United HealthCare. Prior to April 2000, United HealthCare was the Railroad Medicare carrier.

Year	CERT National Error Rates	Railroad Medicare Payments (in millions)	Estimated Improper Payments (in millions)
1997	8.4%	$671	$56.4
1998	8.6%	$673	$57.9
1999	9.4%	$686	$64.5
2000	8.8%	$696	$61.2
2001	8.0%	$762	$61.0
2002	6.4%	$788	$50.4
2003	10.1%	$845	$85.3
2004	5.2%	$923	$48.0
2005	4.4%	$870	$38.3
2006	3.9%	$901	$35.1
2007	3.7%	$897	$33.2
		Total for Years 1997 - 2007:	**$591.3**

For comparative reference, actual 2007 CERT data for Palmetto's non-Railroad operations is shown below:

Carrier	CERT National Error Rates - Actual	Improper Payments (in millions) – Actual
Palmetto South Carolina (880)	4.5%	$48.9
Palmetto Ohio/West Virginia (883/884)	3.6%	$115.8

Evaluation of Benefit Integrity Procedures

This appendix provides the detailed criteria and results of our review of Palmetto's procedures as compared with CMS's Program Integrity Manual (PIM), Chapter 4, Benefit Integrity. Our findings and recommendations are presented beginning on page 15.

Program Integrity Manual Excerpt[27]	Auditor Evaluation of Palmetto BI Procedures
(Section 4.2.2.4) Procedural Requirements	
Maintain confidentiality of referrals to the PSC or ZPIC.	Palmetto's fraud identification and referral procedures do not address this requirement.
The ACs and MACs[28] ensure the performance of the functions below and have written procedures for these functions:	
Ensure all instances where an excluded individual or entity that submits claims for which payment may not be made after the effective date of the exclusion are reported to the OIG (see PIM, chapter 4, §4.19ff).	Palmetto's procedures regarding sanctioned providers do not address this PIM function.
(Section 4.2.2.6) Benefit Integrity Security Requirements	
The following workstation security requirements are specified and implemented: (1) what workstation functions can be performed, (2) the manner in which those functions are to be performed, (3) and the physical attributes of the surrounding of a specific workstation or class of workstation that can access CMS sensitive information. CMS requires that for PSCs[29] and ZPICs[30] all the local workstations as well as the workstations used at home comply with these requirements.	Palmetto's procedures do not address these PIM security requirements.

[27] Criteria excerpts from the PIM are provided for reference.
[28] Affiliated contractors and Medicare administrative contractors
[29] Program Safeguard Contractors
[30] Zone Program Integrity Contractor

Evaluation of Benefit Integrity Procedures

Program Integrity Manual Excerpt[27]	Auditor Evaluation of Palmetto BI Procedures
Direct mailroom staff not to open PSC or ZPIC BI unit mail in the mailroom, unless the PSC or the ZPIC has requested the mailroom do so for safety and health precautions. The PSC and the ZPIC shall perform thorough background and character reference checks, including at a minimum credit checks, for potential employees to verify their suitability for employment with the PSC or the ZPIC BI unit.	
(Section 4.4.1) Requests for Information From Outside Organizations The PSC and the ZPIC BI units shall provide the OIG/OI with requested information, and shall maintain cost information related to fulfilling these requests. Priority I requests shall be fulfilled within thirty (30) days when the information or material is contained in the PSC or the ZPIC BI unit's files unless an exception exists . . . . In order for CMS to track disclosures that are made to law enforcement and health oversight agencies, PSCs and ZPICs shall send a copy of all requests for data to the CMS Privacy Officer	Palmetto's law enforcement procedures do not address these PIM requirements.

Evaluation of Benefit Integrity Procedures

Program Integrity Manual Excerpt[27]	Auditor Evaluation of Palmetto BI Procedures
(Section 4.7) Investigations An investigation is the analysis performed on both proactive and reactive leads (e.g., complaints, data analysis, newspaper articles) in an effort to substantiate the lead or allegation as a case.	Palmetto's investigation procedures have not been updated since 2005. The current PIM references Revision 259 dated June 13, 2008. Palmetto's case closure instructions reference the terms "investigation" and "case" interchangeably and no distinction has been made of how each is to be closed.
(Section 4.7.2) Closing Investigations An investigation shall be closed if it becomes a case (i.e., it is referred to OIG, DOJ[31], FBI, or AUSA[32]), if it is referred back to the AC, MAC, or to another PSC or another ZPIC due to an incorrect referral or misrouting, or if it is closed with administrative action (refer to §4.11.2.8 for FID[33] instructions on closing investigations).	Palmetto's case closure instructions reference the terms "investigation" and "case" interchangeably and no distinction has been made of how each is to be closed.
(Section 4.8) Disposition of Cases The definition of a case includes any and all allegations (regardless of dollar threshold or subject matter) where PSC or ZPIC BI unit staff verify to their own satisfaction that there is potential Medicare fraud (the allegation is likely to be true) and a referral to law enforcement has been performed.	Palmetto's case closure instructions reference the terms "investigation" and "case" interchangeably and no distinction has been made of how each is to be closed.

[31] Department of Justice
[32] Assistant United States Attorney
[33] Fraud Investigation Database

Evaluation of Benefit Integrity Procedures

Program Integrity Manual Excerpt[27]	Auditor Evaluation of Palmetto BI Procedures
(Section 4.11.1.2) Entering OIG Immediate Advisements into the FID The PSC and the ZPIC shall enter all available information into the FID, as an investigation, concurrent with, or within 15 calendar days after, the "immediate advisement" and shall be converted to a case if the OIG accepts it.	Palmetto's law enforcement referral procedures do not address this PIM requirement.
(Section 4.11.2.1) Initial Entry Requirements for Investigations Investigations initiated by the PSC and the ZPIC BI unit shall be entered into the FID within 15 calendar days of the start of the investigation (Investigations are defined in PIM, chapter 4, §4.7).	Palmetto's case activation procedures do not address this PIM requirement.
(Section 4.11.2.3) Initial Entry Requirements for Payment Suspensions The PSC and the ZPIC shall enter information on payment suspensions into the FID Suspension Module no later than 5 business days after the effective date of the suspension.	Palmetto's fraud referral procedure does not address this PIM requirement.
(Section 4.11.2.5) Update Requirements for Cases For cases referred to the OIG, the FBI[34], or other law enforcement agency, updates to the FID case shall be made at least every 3 months (1 month is a maximum of 31 days).	Palmetto's fraud referral procedure does not address this PIM requirement.

[34] Federal Bureau of Investigation

Evaluation of Benefit Integrity Procedures

Program Integrity Manual Excerpt[27]	Auditor Evaluation of Palmetto BI Procedures
(Section 4.11.2.9) Closing Cases An active FID case shall be closed when no further action will be required of the PSC or the ZPIC BI unit by law enforcement agency(ies) working the case and when the law enforcement agency(ies) has ended all its activity on the case; and when all necessary administrative actions have been finalized (i.e., when the calculated overpayment has been referred to the AC or MAC for recoupment).	Palmetto's case closure instructions reference the terms "investigation" and "case" interchangeably and no distinction has been made of how each is to be closed.
(Section 4.19.1) The Program Safeguard Contractor's, Zone Program Integrity Contractor's, AC's, and Medicare Administrative Contractor's Role The PSC and the ZPIC BI unit shall also be responsible for: Contacting OIG/OI when it determines that an administrative sanction against an abusive provider/supplier is appropriate. Providing OIG/OI with appropriate documentation in proposed administrative sanction cases.	Palmetto's sanctioned provider procedures do not address these PIM requirements.
(Section 4.19.2.2) Identification of Potential Exclusion Cases The PSC and ZPIC BI unit shall review and evaluate abuse cases to determine if they warrant exclusion action.	Palmetto's sanctioned provider procedures do not address these PIM requirements.

Evaluation of Benefit Integrity Procedures

Program Integrity Manual Excerpt[27]	Auditor Evaluation of Palmetto BI Procedures
(Section 4.19.4.1) Monthly Notification of Sanction Actions The PSCs, ZPICs, ACs and MACs shall use the information contained in the MED[35] and GAO[36] Debarment list to:	
Determine whether a physician/practitioner/provider or other health care supplier who seeks approval as a provider of services in the Medicare/Medicaid programs is eligible to receive payment[.]	Palmetto's sanctioned provider procedures do not include a review of the GSA Debarment list (EPLS) along with the HHS Exclusion Database (LEIE).
Ensure that sanctioned providers are not being inappropriately paid . . . . The ACs and MACs shall check payment systems periodically to determine whether any individual or entity who has been excluded since January 1982 is submitting claims for which payment is prohibited.	Palmetto's sanctioned provider procedures do not address these PIM requirements.
(Section 4.27) Annual Deceased-Beneficiary Postpayment Review On an annual basis, PSC and ZPIC BI units shall submit a report on the accounting of the improper payments identified by the PSC and ZPIC BI unit and respective overpayments recouped by the AC and MAC. This report shall be due on December 5th of each year and sent to the Primary GTL[37]. The report shall also be sent via e-mail to the Director of the Division of Benefit Integrity Management Operations.	Palmetto's post-payment review procedures do not address this PIM requirement.

[35] Medicare Exclusion Database
[36] GSA maintains the EPLS which is referred to here as the Debarment list.
[37] Government Task Leader

UNITED STATES GOVERNMENT

MEMORANDUM

FORM G-115f (1-92)
RAILROAD RETIREMENT BOARD

August 27, 2009

TO : Letty Benjamin Jay
Assistant Inspector General for Audit

FROM : Henry M. Valiulis
Director of Administration/Senior Executive Officer

Dorothy Isherwood
Director of Programs

SUBJECT: Draft Audit Report
Audit of Railroad Medicare Integrity Program at Palmetto Government Benefits Administrators

Thank you for the opportunity to review the Office of Inspector General's draft audit report entitled "Audit of the Railroad Medicare Integrity Program at Palmetto Government Benefits Administrators (PGBA)." We support efforts to safeguard Medicare payments and ensure that Medicare Integrity Program (MIP) funds are used effectively. While your recommendations deal primarily with our current Medicare contractor PGBA, we are preparing to solicit for an RRB Specialty Medicare Administrative Contract scheduled to be awarded early in fiscal year 2011. We will be mindful of any recommendations that apply to program integrity activities in awarding the replacement contract.

We have reviewed the draft report and are providing the following comments to the recommendations directed to "RRB Officials":

OIG Recommendation #2

Request that Palmetto officials identify and monitor the specific benefit integrity cost components either through revised CAFM II activity reporting or independently of the CAFM II process.

The Office of Administration concurs with the recommendation and will request the funding to perform the monitoring starting with the new contract period on October 1, 2009.

OIG Recommendation #3

Petition CMS to become an active participant in the CERT program;

OIG Recommendation #4

Determine the CERT compliance error rate applicable to its Part B workload; and

OIG Recommendation #5

Request funding to support a benefit integrity program commensurate with Railroad Medicare's exposure to improper payments as estimated using CERT methodology.

The Office of Administration concurs with recommendation nos. 3, 4 and 5 and will submit the request along with the budget request for FY 2010. The Railroad Specialty MAC solicitation currently being formed would address and provide for these functions and program safeguards in coordination with CMS.

OIG Recommendation #11

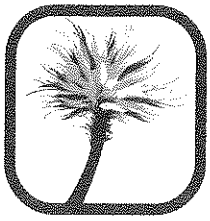
We recommend that RRB officials work with the Program Support Division to establish a long-range planning process for conducting recurring reviews of Palmetto's MIP components.

The Office of Programs concurs with Recommendation 11. The Unemployment and Programs Support Division will establish a long-range planning process for conducting recurring reviews of Palmettos' MIP components by September 30, 2009.

In conclusion, the responsible officials in the Office of Administration and Office of Programs agree with the OIG's recommendations in their respective areas, and remain committed to strengthening the Medicare integrity program in cooperation with PGBA and CMS. Thank you again for the opportunity to comment on the draft report and please contact us if you have any questions or require additional information.

cc: Mr. Bruce W. Hughes
President and Chief Operating Officer
Palmetto GBA, LLC
2300 Springdale Drive, Bldg. One, Mail Code AG-A03
Camden, SC 29020-1728

Michael S. Schwartz, Chairman
Jerome F. Kever, Management Member
V. M. Speakman, Jr., Labor Member
Catherine A. Leyser, Director of Assessment and Training
Joseph Giansante, Medicare Contractor Operations Specialist



Palmetto GBA℠
PARTNERS IN EXCELLENCE℠

Bruce W. Hughes
President and Chief Operating Officer

September 1, 2009

Letty Benjamin Jay
Assistant Inspector General for Audit
United States Railroad Retirement Board
Office of Inspector General
844 N Rush Street
Chicago, IL 60611-2092

Dear Ms. Jay:

Enclosed is Palmetto GBA's response to the recommendations supplied by your office, per draft audit report dated August 6, 2009. The report was conducted by members of your staff over an eight month period, from December 2008 – August 2009. We received the report on August 7, 2009 and were requested to respond by August 27, 2009. At the Fieldwork Exit Conference your staff held on May 13, 2009 we were given an outline of the meeting stating the response to the draft report would be due within 30 calendar days of receipt of the draft report. We did not receive a copy o f the draft report at the exit conference. The report contains a significant amount of data that we have not substantiated and due to the short timeframe in which we have to respond, it is not feasible to do so.

It should be noted that effective with the CMS transition to the Program Safeguard Contractor (PSC) that the Railroad Medicare contract was excluded. Many of the recommendations made in this audit report are handled by the PSC, who works in conjunction with the contractors. The PIM specifically states that proactive fraud investigations are the responsibility of the PSC. In regards to those programs that Railroad Medicare was excluded from at the direction of CMS, we will work with RRB officials to determine if they will be entering into discussions with CMS to change the scope of work required by Palmetto GBA.

As requested, the attached chart reflects the OIG recommendations and our responses.

Sincerely,

Bruce W. Hughes

cc: Michael S. Schwartz, Chairman
Jerome F. Kever, Management Member
V.M. Speakman, Jr., Labor Member
Dorothy Isherwood, Director of Programs
Henry M. Valiulis, Director of Administration
Catherine A. Leyser, Director of Assessment and Training
Joseph Giansante, Medicare Contractor Operations Specialist
Robin Spires, Vice President, Operations, Palmetto GBA
Gina Jenkins, Senior Director, Augusta Operations & RRB Program Manager, Palmetto GBA

Report Reference	Audit Recommendations for Palmetto Officials:	Palmetto GBA response:
Page 7, **Item 1**	Work with CMS and RRB officials to obtain the budget and staff resources needed to conduct the proactive fraud investigation and data analysis responsibilities outlined in the PIM.	The Railroad BI unit has been successful in the past in joining with the Department of Health and Human Services OIG along with other law enforcement agencies in identifying fraud in the Medicare program. We are fully supportive of this recommendation and in full agreement with the Railroad Retirement Board response to pursue the necessary funding to conduct the proactive fraud investigation and data analysis responsibilities outlined in the PIM.
Page 11 **Item 6**	Revise its sanction monitoring procedure to ensure that the Provider Enrollment unit performs a reconciliation with the EPLS	General Services Administration's (GSA) Excluded Parties List System (EPLS) is referenced in Chapter 10 under the prescreening of 855 applications section. Below is the verbiage: *"Confirm that the applicant, all individuals and entities listed on the application and any names or entities ascertained through the use of an independent verification source, are not presently excluded from the Medicare program by the HHS Office of the Inspector General (OIG). Contractors shall confirm and validate data through Qualifier.net the Medicare Exclusion Database, and the General Services Administration (GSA) debarment list, in accordance with existing CMS instructions and directives."* Based on the above information, the EPLS system check would be done during the time that an 855 enrollment form is completed and approved by the Part B Carrier(s). If the provider was not approved by the Part B Carrier(s), per the instructions from Chapter 10 stated above, Railroad would not find the provider(s) as being "active" on the Part B Carriers' files (SUPERPES). All providers are verified against the Part B Carrier files (SUPERPES), before Railroad adds the provider and issues a provider number in the RR provider file database. As stated during the OIG Audit, Railroad has not added providers to the Railroad Provider File until the provider(s) have submitted an 855 enrollment application to their Part B Carrier and that provider has been credentialed and enrolled by the Part B Carrier(s). It is important to note that per CMS instruction, Railroad Medicare does not process 855 enrollment applications. All existing providers are checked monthly against the LEIE/OIG exclusion list and flagged as SANCTIONED as required which will stop any RR Medicare payments. Also, a copy of the monthly OIG exclusion list with our provider findings is supplied to the Benefits Integrity Investigator. **Effective August 13, 2008 we re-started supplying the completed monthly OIG exclusion report and included copies of all 2008 exclusions for payment investigation purposes. After the RRB OIG Audit was performed in Augusta, it was suggested that we return to providing this

		report to the Benefits Integrity Unit and we have done so.
Page 11, **Item 7**	Establish BI unit procedures for investigating payments submitted by excluded providers prior to their exclusion date and refer claims to the RRB-OIG's Office of Investigations for further investigation as appropriate	In conjunction with the response to Item 6, effective August 13, 2008, Provider Enrollment has been providing BIU with a monthly OIG exclusion list. The list provides BIU with any RRB sanctioned providers. BIU has created a procedure to perform data analysis on claims prior to the exclusion date. The data analysis will include all claims dated back 5 years from the date of exclusion. The claims and any other relevant information will be reviewed for fraudulent activity. If any fraud is suspected, an immediate referral will be made to RRB-OIG Office of Investigation. **Effective August 13, 2008 we re-started supplying the completed monthly OIG exclusion report and included copies of all 2008 exclusions for payment investigation purposes. The supplying of the completed monthly OIG exclusion report had been discontinued at our Benefits Integrity Unit's request due to lack of staffing to work the monthly list. After the RRB OIG Audit was performed in Augusta, it was suggested that we return to providing this report to the Benefits Integrity Unit and we have done so.
Page 12 **Item 8**	Coordinate the referral of high dollar payments and receivables, those in excess of $10,000, with the RRB-OIG's Office of Investigations	Concur – Palmetto GBA Finance Department will provide BIU with a monthly RRB Accounts Receivable (AR) report. Any overpayments over $10,000 will be referred to the BIU Investigator. If no overpayments are demanded for any given month, an email from Finance will be sent to BIU notifying the Investigator. Any receivables or payments in excess of $10,000 transferred to the BIU Investigator from Finance will be immediately referred to RRB OIG Office of Investigation.
Page 13, **Item 9**	Request specific funding for fraud related training and actively monitor staff compliance with the CMS' PIM and the RRB contract's benefit integrity training requirements	Non concur - due to previous reviews by RRB Program Support Staff, all employees receive technical based training (TBT), at a minimum, of once per year. Each associate working on the RRB contract receives a minimum of 15 minutes Fraud Awareness training, totaling approximately 50 hours of fraud awareness training annually. In addition, the BIU investigator is currently obtaining Certified Fraud Examiner status.
Page 14 **Item 10**	Correct the identified BI unit procedural deficiencies and ensure that procedures have been developed to address all CMS PIM requirements.	Concur. Procedures were established August 13, 2008. As noted while the auditors were on-site, some of the procedures listed in the audit report had established procedures and were provided at the time of review. (Example: page 14, bullet three “Reimbursement when the beneficiary has paid a provider for services and the provider has received payment.” The procedures were in existence and supplied to auditors when they were on site.) In addition, work instructions have been developed and are available upon request. It should be noted, any procedures needing to be revised to reflect CMS PIM requirements are complete. Palmetto is ISO 9000 certified. BIU completed an ISO 9000 audit on July 28, 2009, which resulted in no deficiencies and CMS control objectives were met

Page 16, **Item 12**	Classify RRB-OIG's Office of Investigations referrals and other BI unit information requests as Priority I or PriorityII and monitor the timeliness of its responses to ensure compliance with PIM requirements	BIU responds immediately to any rush request from RRB-OIG. Data analysis request are forwarded to Medicare Statistical Analysis Department (MSAD), which is completed within 3 to 4 weeks. Depending on the size of the request, it could take longer. BIU communicates with the point of contact Special Agent to inform the OIG of any request being late or taking an extended time to complete. With a high volume of request from RRB-OIG, MSAD has created a query for BIU to help process requests more efficiently. Priority I – This type of request is a top priority request requiring a quick turnaround. The information is essential to the prosecution of a provider. The request shall be completed with the utmost urgency. Priority I requests shall be fulfilled within thirty (30) days when the information or material is contained in the BI unit's files Priority II – This type of request is less critical than a Priority I request. Development requests may require review or interpretation of numerous records, extract of records from retired files in a warehouse or other archives, or soliciting information from other sources. Based on the review of its available resources, the PSC and the ZPIC BI unit shall inform the requestor what, if any, portion of the request can be provided. The PSC and the ZPIC BI unit shall provide the relevant data, reports, and findings to the requesting agency in the format(s) requested. The BI units shall respond to such requests within 45 calendar days, when possible. Procedures have been established for the above instructions taken from the Program Integrity Manual and are available upon request.
Page 17, **Item 13**	Formalize their assessment that no Medical Director is necessary and request that CMS waive the PIM requirement; and	Concur. We will submit a request for waiver to the Railroad Retirement Board. The RRB handles all waiver requests for the Railroad Medicare contract. Please note that the auditors were informed that the CMD position for the RRB contract was eliminated by the previous contractor well before Palmetto GBA became the Railroad Medicare contractor in September 2000. During the transition from United HealthCare to Palmetto GBA, no requirement was made by the RRB to employ a CMD for this contract.
Page 17, **Item 14**	Establish formal procedures for the Railroad Medicare program to obtain the services of other Medical Directors as necessary	Concur. We will document procedures to obtain services by current Palmetto Medical Directors to review RRB cases, if necessary. As noted to the auditors, as Medical Review management and clinicians determine that CMD review is necessary, we currently utilize Palmetto CMDs; however, since the Railroad contract does not formulate LCDs the need does not arise frequently.
Page 18, **Item 15**	Request that periodic reports be provided to the BI unit detailing	Concur – BIU Investigator contacts the Finance Department, regarding any collections on BIU overpayments. On request from the BIU Investigator, the Finance Unit provides a detailed report

	the status of BI collections on a case-by-case basis	of any collections that have occurred on BIU overpayments.

Note: The RRB OIG audit report included recommendations for RRB Officials, the Palmetto GBA response does not include responses to those items noted in the report for RRB Officials (Items 2, 3, 4, 5, and 11).