Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

PALMETTO GBA, LLC, INAPPROPRIATELY PAID HOSPITALS' MEDICARE CLAIMS SUBJECT TO THE POSTACUTE CARE TRANSFER POLICY IN JURISDICTION 1

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Gloria L. Jarmon
Deputy Inspector General

May 2013
A-09-12-02038

Office of Inspector General

https://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at https://oig.hhs.gov

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.

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

Palmetto GBA inappropriately paid Medicare claims subject to the postacute care transfer policy, resulting in overpayments to 188 hospitals totaling $10.8 million over 4 years. The hospitals improperly coded claims as discharges to home rather than as transfers to postacute care.

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews identified Medicare overpayments to hospitals that did not comply with the postacute care transfer policy. These hospitals transferred inpatients to certain postacute care settings but claimed the higher reimbursement associated with discharges to home. In those reports, we recommended that the Centers for Medicare & Medicaid Services (CMS) provide education to make hospitals aware of the transfer policy and require Medicare contractors to implement system edits to prevent and detect postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations and initiated collection efforts on the overpayments that we identified. In addition, CMS implemented system edits to identify improperly coded hospital claims. However, in recent OIG reviews of hospitals' compliance with Medicare billing requirements in Jurisdiction 1 (which consists of three States and three territories), we identified Medicare overpayments to hospitals that did not comply with the postacute care transfer policy.

The objective of this review was to determine whether Palmetto GBA, LLC (Palmetto), the Medicare contractor for Jurisdiction 1, appropriately paid hospitals' Medicare claims subject to the postacute care transfer policy.

BACKGROUND

Medicare's postacute care transfer policy distinguishes between discharges and transfers of beneficiaries from hospitals under the inpatient prospective payment system. Consistent with the policy, Medicare makes full Medicare Severity Diagnosis-Related Group (MS-DRG) payments to hospitals that discharge inpatients to their homes. In contrast, for specified MS-DRGs, Medicare pays hospitals that transfer inpatients to certain postacute care settings, such as home health care and skilled nursing facilities, a per diem rate for each day of the stay, not to exceed the full MS-DRG payment for a discharge. Typically, the full MS-DRG payment is higher than the per diem payment dependent upon the patient's length of stay in the hospital. CMS requires hospitals to include a two-digit patient discharge status code on all inpatient claims to identify a beneficiary's status at the conclusion of an inpatient stay. Whether Medicare pays for a discharge or a transfer depends on the patient discharge status code indicated on the inpatient claim.

In 2004, CMS implemented Common Working File (CWF) edits to identify transfers improperly coded as discharges. Specifically, if an inpatient claim is processed and paid before a corresponding postacute care claim is processed, postpayment edits for inpatient claims are designed to generate an "alert" with associated detail (trailer) information that identifies overpayments on the inpatient claim.

Our review covered $31,447,024 in Medicare Part A payments for 1,656 claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and that had dates of service ending in calendar years (CYs) 2008 through 2011. These claims were submitted by 188 short-term acute-care hospitals in Jurisdiction 1.

WHAT WE FOUND

Palmetto inappropriately paid 1,656 Medicare claims subject to the postacute care transfer policy during CYs 2008 through 2011. The hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home rather than transferred to postacute care. Of these claims, 97 percent were followed by claims for home health services, and 3 percent were followed by claims for services in other postacute care settings. Because the postpayment edits were not working properly, Palmetto did not receive the CWF edit alerts or associated trailer information notifying it that the miscoded claims required payment adjustments. Consequently, Palmetto overpaid the hospitals by $10,836,130.

As a result of our review, Palmetto notified the CWF maintenance contractor that it was not receiving the edit alerts or associated trailer information.

WHAT WE RECOMMEND

We recommend that Palmetto:

- recover $10,836,130 in identified overpayments;
- educate Jurisdiction 1 hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered; and
- continue working with the CWF maintenance contractor to ensure that it receives the CWF edit alerts and associated trailer information.

PALMETTO COMMENTS

In written comments on our draft report, Palmetto provided information on actions that it had taken to address our recommendations.

TABLE OF CONTENTS

INTRODUCTION 1

Why We Did This Review 1

Objective 1

Background 1
Medicare's Inpatient Prospective Payment System 1
Postacute Care Transfer Policy 1
Medicare Contractors 2
Medicare Claims Processing Systems 2
Palmetto GBA, LLC 3

How We Conducted This Review 3

FINDINGS 3

Federal Requirements 4

Hospitals Improperly Coded Claims as Discharges to Home Rather Than as Transfers to Postacute Care 4

Palmetto Did Not Receive Edit Alerts Notifying It That Miscoded Claims Required Payment Adjustments 5

RECOMMENDATIONS 5

PALMETTO COMMENTS 5

APPENDIXES

A: Audit Scope and Methodology 6

B: Related Office of Inspector General Reports 8

C: Palmetto Comments 9

INTRODUCTION

WHY WE DID THIS REVIEW

Previous Office of Inspector General (OIG) reviews identified Medicare overpayments to hospitals that did not comply with the postacute care transfer policy. These hospitals transferred inpatients to certain postacute care settings but claimed the higher reimbursement associated with discharges to home. In those reports, we recommended that the Centers for Medicare & Medicaid Services (CMS) provide education to make hospitals aware of the transfer policy and require Medicare contractors to implement system edits to prevent and detect postacute care transfers that are miscoded as discharges. CMS generally concurred with our recommendations and initiated collection efforts on the overpayments that we identified. In addition, CMS implemented system edits to identify improperly coded hospital claims. However, in recent OIG reviews of hospitals' compliance with Medicare billing requirements in Jurisdiction 1 (which consists of three States and three territories), we identified Medicare overpayments to hospitals that did not comply with the postacute care transfer policy.

OBJECTIVE

Our objective was to determine whether Palmetto GBA, LLC (Palmetto), the Medicare contractor for Jurisdiction 1, appropriately paid hospitals' Medicare claims subject to the postacute care transfer policy.

BACKGROUND

Medicare's Inpatient Prospective Payment System

The Social Security Act (the Act) established the inpatient prospective payment system (IPPS) for inpatient hospital services provided to Medicare beneficiaries (§§ 1886(d) and (g)). Under the IPPS, CMS pays hospital costs at predetermined rates for patient discharges. A hospital inpatient is considered discharged from a hospital when the patient is formally released from or dies in the hospital.

CMS's payment rates vary according to the Medicare Severity Diagnosis-Related Group (MS-DRG) to which a beneficiary's stay is assigned and the severity level of the patient's diagnosis. The MS-DRG payment is, with certain exceptions, intended to be payment in full to the hospital for all inpatient costs associated with the beneficiary's stay.

Postacute Care Transfer Policy

Section 4407 of the Balanced Budget Act of 1997, P.L. No. 105-33, added § 1886(d)(5)(J) to the Act to establish the Medicare postacute care transfer policy. This provision and its implementing regulations (42 CFR § 412.4(c)) state that a postacute care transfer occurs when a beneficiary whose hospital stay was classified within specified MS-DRGs is released from an IPPS hospital in one of the following situations:

- The beneficiary is admitted on the same day to a hospital or hospital unit that is not reimbursed under the IPPS.

- The beneficiary is admitted on the same day to a skilled nursing facility.

- The beneficiary receives home health services from a home health agency, the services are related to the condition or diagnosis for which the beneficiary received inpatient hospital services, and the services are provided within 3 days of the beneficiary's hospital discharge date.

Medicare makes the full MS-DRG payment to a hospital that discharges an inpatient to home. In contrast, Medicare pays a hospital that transfers an inpatient to postacute care a per diem rate for each day of the stay, not to exceed the full MS-DRG payment that would have been made if the inpatient had been discharged to home. Typically, the full MS-DRG payment is higher than the per diem payment dependent upon the patient's length of stay in the hospital.

CMS requires hospitals to include a two-digit patient discharge status code on all inpatient claims to identify a beneficiary's status at the conclusion of an inpatient stay. Whether Medicare pays for a discharge or a transfer depends on the patient discharge status code indicated on the inpatient claim.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare claims submitted for hospital services. The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse.

Medicare Claims Processing Systems

Medicare contractors use the Fiscal Intermediary Standard System (FISS) to process inpatient and outpatient claims submitted by hospitals in their designated jurisdictions. After being processed through the FISS, and before payment, all Medicare contractor claims are sent to CMS's Common Working File (CWF) system for verification, validation, and payment authorization. Once the CWF has processed a claim, it electronically transmits a "trailer record" to the contractor. The trailer record includes information regarding potential errors on the claim. Both the FISS and CWF contain edits to prevent and detect overpayments.

On January 1, 2004, CMS implemented CWF edits to identify improperly coded hospital claims and instructed the Medicare contractors to automatically cancel hospital claims that had incorrect patient discharge status codes. On March 15, 2004, CMS revised these edits and established new criteria for an automatic claim cancellation. Specifically, if an inpatient claim is processed and paid before a corresponding postacute care claim is processed, postpayment edits for inpatient claims are designed to generate an "alert" with associated trailer information that identifies overpayments on the inpatient claim. However, if the postacute care claim is processed and paid

before the inpatient claim is processed, prepayment edits for inpatient claims are designed to reject the incoming inpatient claim.

Palmetto GBA, LLC

In September 2008, Palmetto GBA, LLC (Palmetto), assumed full responsibility as the Medicare contractor for Jurisdiction 1 hospitals in three States (California, Hawaii, and Nevada) and three territories (American Samoa, Guam, and Northern Mariana Islands).[1]

HOW WE CONDUCTED THIS REVIEW

Our review covered $31,447,024 in Medicare Part A payments for 1,656 claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and that had dates of service ending in calendar years (CYs) 2008 through 2011. These claims were submitted by 188 short-term acute-care hospitals in Jurisdiction 1.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from Medicare payment files; we did not assess the completeness of the files. Through data analysis, we identified inpatient claims subject to the postacute transfer policy that were improperly coded as discharges to home.

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.

Appendix A contains the details of our audit scope and methodology. Appendix B contains a list of related OIG reports on hospitals' submissions of Medicare claims subject to the postacute transfer policy.

FINDINGS

Palmetto inappropriately paid 1,656 Medicare claims subject to the postacute care transfer policy during CYs 2008 through 2011. The hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home rather than transferred to postacute care. Of these claims, 97 percent were followed by claims for home health services, and 3 percent were followed by claims for services in other postacute care settings. Because the postpayment edits were not working properly, Palmetto did not receive the CWF edit alerts or associated trailer information notifying it that the miscoded claims required payment adjustments. Consequently, Palmetto overpaid the hospitals by $10,836,130.

[1] Before September 2008, providers in Jurisdiction 1 processed Medicare claims through separate fiscal intermediaries. In September 2008, Palmetto became fully responsible as the Medicare contractor for these States and territories and is therefore responsible for collecting any overpayments and resolving the issues related to this audit.

FEDERAL REQUIREMENTS

Federal regulations state that for a beneficiary whose hospital stay was classified within one of the specified MS-DRGs, a discharge from an IPPS hospital to a qualifying postacute care setting is considered a transfer (42 CFR § 412.4(c)). The qualifying postacute care settings are (1) hospitals or hospital units that are not reimbursed under the IPPS,[2] (2) skilled nursing facilities, and (3) home health care if services are provided within 3 days of the discharge.

CMS requires hospitals to include patient discharge status codes on all inpatient claims.[3] When a hospital discharges a beneficiary to home, patient discharge status code 01 should be used. However, when a beneficiary is transferred to a setting subject to the postacute care transfer policy, a different discharge status code should be used, depending on the type of postacute care setting. For example, patient discharge status code 03 should be used when the beneficiary is transferred to a skilled nursing facility, and patient discharge status code 06 should be used when a beneficiary is transferred to home for home health services.[4] The Federal Register emphasizes that the hospital is responsible for coding the bill based on its discharge plan for the patient. If the hospital subsequently determines that postacute care was provided, it is responsible for either coding the original bill as a transfer or submitting an adjusted claim.[5]

The *Medicare Financial Management Manual*, Pub. 100-06, chapter 7, § 10, states that the contractor must administer the Medicare program efficiently and economically and refers to the Medicare contractors' Statement of Work, which further states that the contractor must establish and maintain efficient and effective internal controls.

HOSPITALS IMPROPERLY CODED CLAIMS AS DISCHARGES TO HOME RATHER THAN AS TRANSFERS TO POSTACUTE CARE

Palmetto inappropriately paid 1,656 Medicare claims subject to the postacute care transfer policy during CYs 2008 through 2011. Hospitals improperly coded these claims as discharges to home rather than as transfers to postacute care by using the incorrect patient discharge status codes. Of these claims:

- 1,609 claims were followed by claims for home health services provided within 3 days of the discharge date, resulting in $10,472,896 of overpayments to the discharging hospitals;

[2] Section 1886(d)(5)(J) of the Act refers to hospitals and hospital units that are not reimbursed under the IPPS as "not subsection (d) hospitals." Section 1886(d)(1)(B) of the Act identifies the hospitals and hospital units that are excluded from the term "subsection (d) hospitals," such as psychiatric hospitals and units, rehabilitation hospitals and units, children's hospitals, long-term-care hospitals, and cancer hospitals.

[3] *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 25, § 75.2.

[4] *Medicare Claims Processing Manual*, Pub. No. 100-04, chapter 3, § 40.2.4; Program Memorandum, Transmittal No. A-01-39, Mar. 22, 2001, Change Request 1565; Medicare Learning Network's MLN Matters Number: SE0801; and MLN Matters Number: MM4046, Related Change Request 4046.

[5] 63 Fed. Reg. 40954, 40980 (July 31, 1998). See also MLN Matters Number: SE0408.

- 34 claims were followed by claims for skilled nursing services provided on the same day as the discharge date, resulting in $234,787 of overpayments to the discharging hospitals; and

- 13 claims were followed by claims for admissions to non-IPPS hospitals or hospital units on the same day as the discharge date, resulting in $128,447 of overpayments to the discharging hospitals.

As a result, Palmetto overpaid 188 hospitals by $10,836,130 for CYs 2008 through 2011. The overpayments represented the difference between the full MS-DRG payments and the per diem rates that should have been applied.

PALMETTO DID NOT RECEIVE EDIT ALERTS NOTIFYING IT THAT MISCODED CLAIMS REQUIRED PAYMENT ADJUSTMENTS

Because the postpayment edits for inpatient claims were not working properly, Palmetto did not receive the CWF edit alerts or associated trailer information notifying it that the miscoded claims required payment adjustments. Therefore, Palmetto overpaid 188 hospitals in Jurisdiction 1 during CYs 2008 through 2011 for claims that did not comply with the postacute care transfer policy.

As a result of our review, Palmetto notified the CWF maintenance contractor that Palmetto was not receiving the edit alerts or associated trailer information.

RECOMMENDATIONS

We recommend that Palmetto:

- recover $10,836,130 in identified overpayments;

- educate Jurisdiction 1 hospitals on the importance of reporting the correct patient discharge status codes on transfer claims, especially when home health services have been ordered; and

- continue working with the CWF maintenance contractor to ensure that it receives the CWF edit alerts and associated trailer information.

PALMETTO COMMENTS

In written comments on our draft report, Palmetto provided information on actions that it had taken to address our recommendations. Palmetto's comments are included in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our review covered $31,447,024 in Medicare Part A payments for 1,656 claims with specified MS-DRGs in which beneficiaries were transferred to postacute care and that had dates of service ending in CYs 2008 through 2011. These claims were submitted by 188 short-term acute-care hospitals in Jurisdiction 1.

Our audit allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from Medicare payment files; we did not assess the completeness of the files. Through data analysis, we identified inpatient claims subject to the postacute transfer policy that were improperly coded as discharges to home. We limited our review of Palmetto's internal controls to those applicable to implementation of Medicare's postacute care transfer policy. We did not evaluate the medical records of the IPPS hospitals from which the beneficiaries in our review were discharged to determine whether there was a written plan of care for the provision of home health services.

We conducted our fieldwork at Palmetto in Columbia, South Carolina, from March to October 2012.

METHODOLOGY

To accomplish our objective, we:

- reviewed Federal laws, regulations, and guidance;
- used CMS's National Claims History File to identify inpatient claims with specified MS-DRGs, during our audit period, for beneficiaries who received certain postacute care services after inpatient stays;
- used computer matching, data mining, and data analysis techniques to identify for review 1,769 claims coded as discharges to home;
- sent the 1,769 claims to Palmetto officials to verify whether the claims were canceled, adjusted, or miscoded and to determine the cause of the miscoding;
- excluded from our review 113 claims that had been canceled or adjusted before our review;
- interviewed and reviewed documentation provided by Palmetto officials to understand how they processed claims and to determine why Palmetto made payments for the miscoded claims;

- used CMS's Pricer program to reprice each improperly paid claim to determine the transfer payment amount, compared the repriced payment with the actual payment, and determined the value of the overpayment; and

- discussed the results of our review with Palmetto officials.

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.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Compliance Review of Hoag Memorial Hospital Presbyterian for Calendar Years 2008 Through 2011[6]	A-09-12-02012	12/10/12
Medicare Overpaid Some Fiscal Year 2008 and 2009 Jurisdiction 4 Inpatient Rehabilitation Facility Claims That Did Not Comply With Transfer Regulations	A-04-11-00078	04/24/12
Medicare Compliance Review of John Muir Medical Center, Walnut Creek, for Calendar Years 2008 Through 2010[6]	A-09-11-02060	02/23/12
Medicare Compliance Review of University of California, San Diego, Medical Center for Calendar Years 2008 and 2009[6]	A-09-11-02055	02/23/12
Medicare Compliance Review of University of California, San Francisco, Medical Center for Calendar Years 2008 and 2009[6]	A-09-11-02034	09/21/11
Hospital Compliance With Medicare's Postacute Care Transfer Policy During Fiscal Years 2003 Through 2005	A-04-07-03035	02/27/09

[6] The postacute care transfer issue was only one of the findings in this report.

APPENDIX C: PALMETTO COMMENTS

PALMETTO GBA
A CELERIAN GROUP COMPANY

PO BOX 100134 | COLUMBIA, SC 29202-3134 | PALMETTOGBA.COM | ISO 9001

W. JOE JOHNSON
President and Chief Operating Officer

April 15, 2013

Lori A. Ahlstrand
Office of Inspector General
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
San Francisco, CA 94103

Reference: Draft Report No. A-09-12-02038

Dear Ms. Ahlstrand:

This letter is in response to the recent Office of Inspector General (OIG) report entitled "*Palmetto GBA, LLC, Inappropriately Paid Hospitals' Medicare Claims Subject to the Postacute Care Transfer Policy in Jurisdiction 1.* We appreciate the feedback your review provided and are committed to continuously improving our service to the Medicare beneficiaries and providers we serve.

During the audit period CYs 2008 through 2011 hospitals used incorrect patient discharge status codes on their claims, indicating that the patients were discharged to home rather than transferred to postacute care.

During the audit period approximately 1,656 claims were selected in which:

(1) 1,609 claims were followed by claims for home health services provided within 3 days of the discharge date, resulting in $10,472,896 of overpayments to the discharging hospitals.

(2) 34 claims were followed by claims for skilled nursing services provided on the same day as the discharge date, resulting in $234,787 of overpayments to the discharging hospitals.

(3) 13 claims were followed by claims for admissions to non-IPPS hospitals or hospital units on the same day as the discharge date, resulting in $128,447 of overpayments to the discharging hospitals.

In several cases, neither the Fiscal Intermediary Standard System (FISS) nor the Common Working File (CWF) had edits working properly. Palmetto did not receive the CWF edit alerts or associated trailer information notifying it that that the miscoded claims required payment adjustments. Therefore, Palmetto GBA overpaid 188 hospitals in Jurisdiction 1 during this time period.

As a result the following was recommended by your office:

- **Recover the $10,836,130 identified overpayments.**

  Palmetto GBA Response:

  All claims identified in the audit were adjusted either by the provider or by Palmetto GBA.

- **Educate Jurisdiction 1 hospitals on the importance of reporting the correct patient discharge status codes o transfer claims, especially when home health services have been order; and**

  Palmetto GBA Response:

  Palmetto GBA conducted a webinar on April 10, 2013 on Part A Inpatient PPS Transfers and Repeat Admissions.

- **Continue working with the CWF maintenance contractor to ensure hta it receives the CWF edit alerts and associated trailer information.**

  Palmetto GBA Response:

  Palmetto GBA continues coordination with FISS and CWF to determine the non-transfer of information as it pertains to the alerts. Recent examples were supplied by CWF and sent to the FISS maintainer to identify problems. Results pending.

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

Sincerely

Walter J. Johnson

cc: Amy Drake, COR, CMS
Sandra Brown, CMS
Mike Barlow, Palmetto GBA
Carol Sutton, Palmetto GBA