DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

June 12, 2009

Report Number: A-06-08-00037

Regina Favors
President and Chief Executive Officer
Pinnacle Business Solutions, Inc.
Medicare Services
515 West Pershing Boulevard
North Little Rock, Arkansas 72114-2147

Dear Ms. Favors:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Louisiana Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc., for the Period January 1 Through December 31, 2005." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to this official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, OIG reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act. Accordingly, this report will be posted on the Internet at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me, or contact Warren Lundy, Audit Manager, at (405) 605-6183 or through e-mail at Warren.Lundy@oig.hhs.gov. Please refer to report number A-06-08-00037 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR LOUISIANA MEDICARE PART B CLAIMS PROCESSED BY PINNACLE BUSINESS SOLUTIONS, INC., FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

June 2009
A-06-08-00037

Office of Inspector General

http://oig.hhs.gov

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Pursuant to the Freedom of Information Act, 5 U.S.C. § 552, Office of Inspector General reports generally are made available to the public to the extent that information in the report is not subject to exemptions in the Act.

OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS), which administers the program, contracts with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers). CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed.

Carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File to process Part B claims. These systems can detect certain improper payments during prepayment validation.

During calendar year (CY) 2005, Arkansas Blue Cross Blue Shield, now doing business as Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 18,500 providers in Louisiana. Pinnacle processed more than 11.6 million Louisiana Part B claims, 35 of which resulted in payments of $10,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Pinnacle's high-dollar Medicare payments to Louisiana Part B providers in 2005 were appropriate.

SUMMARY OF FINDINGS

Of the 35 high-dollar payments that Pinnacle made to providers, 33 were appropriate. However, Pinnacle overpaid two providers $49,760 for the remaining two claims. Both providers contacted Pinnacle and refunded the overpayments during our fieldwork.

Pinnacle made the overpayments because the providers billed for the wrong Healthcare Common Procedure Coding System (HCPCS) code or billed for excessive units. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2005 to detect and prevent payments for these types of errors.

RECOMMENDATION

We recommend that Pinnacle ensure that the identified overpayments totaling $49,760 have been recovered in full.

PINNACLE COMMENTS

In comments on our draft report, Pinnacle agreed with our findings and stated that the two claims in error have been refunded. Pinnacle also indicated that it is working to ensure that these types

of claims are monitored for potential overpayments. Pinnacle's comments are included in their entirety as the Appendix.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act (the Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Part B Carriers

Prior to October 1, 2005, section 1842(a) of the Act authorized CMS to contract with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers).[1] Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process and pay providers' claims, carriers currently use the Medicare Multi-Carrier Claims System and CMS's Common Working File. These systems can detect certain improper payments during prepayment validation.

CMS guidance requires providers to bill accurately and to report units of service as the number of times that a service or procedure was performed. During calendar year (CY) 2005, providers nationwide submitted approximately 819 million claims to carriers. Of these, 13,402 claims resulted in payments of $10,000 or more (high-dollar payments). We consider such claims to be at high risk for overpayment.

Pinnacle Business Solutions, Inc.

During CY 2005, Arkansas Blue Cross Blue Shield, now doing business as Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 18,500 providers in Louisiana. Pinnacle processed more than 11.6 million Louisiana Part B claims, 35 of which resulted in payments of $10,000 or more (high-dollar payments).

"Medically Unlikely" Edits

In January 2007, after our audit period, CMS required carriers to implement units-of-service edits referred to as "medically unlikely edits." These edits are designed to detect and deny unlikely Medicare claims on a prepayment basis. According to the "Medicare Program Integrity Manual," Publication 100-08, Transmittal 178, Change Request 5402, medically unlikely edits test claim lines for the same beneficiary, Healthcare Common Procedure Coding System (HCPCS) code, date of service, and billing provider against a specified number of units of service. Carriers must deny the entire claim line when the units of service billed exceed the specified number.

[1]The Medicare Modernization Act of 2003, P.L. No. 108-173, which became effective on October 1, 2005, amended certain sections of the Act, including section 1842(a), to require that Medicare administrative contractors replace carriers and fiscal intermediaries by October 2011.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Pinnacle's high-dollar Medicare payments to Louisiana Part B providers in 2005 were appropriate.

Scope

We identified 37 high-dollar payments that Pinnacle processed during CY 2005. Pinnacle adjusted two of the payments to less than $10,000 prior to the start of our audit. We reviewed the remaining 35 high-dollar payments, which totaled $633,509.

We limited our review of Pinnacle's internal controls to those applicable to the 35 claims because our objective did not require an understanding of all internal controls over the submission and processing of claims. Our review allowed us to establish reasonable assurance of the authenticity and accuracy of the data obtained from the National Claims History file, but we did not assess the completeness of the file.

We performed our fieldwork from April 2008 to February 2009.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and guidance;
- used CMS's National Claims History file to identify Medicare Part B claims with high-dollar payments;
- reviewed Medicare Multi-Carrier Claims System claim histories for claims with high-dollar payments to determine whether the claims had been canceled and/or superseded by revised claims or whether payments remained outstanding at the time of our fieldwork;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and
- coordinated our claim review, including the calculation of any overpayments, with Pinnacle.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATION

INAPPROPRIATE PINNACLE PAYMENTS

The CMS "Carriers Manual," Publication 14, part 2, section 5261.1, requires that carriers accurately process claims in accordance with Medicare laws, regulations, and instructions. Section 5261.3 of the manual requires carriers to effectively and continually analyze "data that identifies aberrancies, emerging trends and areas of potential abuse, overutilization or inappropriate care, and . . . on areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes."

Of the 35 high-dollar payments that Pinnacle made to providers, 33 were appropriate. However, Pinnacle overpaid two providers a total of $49,760.

- One provider billed for HCPCS code J9015 when it should have billed for HCPCS code J9305. The provider was paid $32,259 for the incorrect claim. According to a Pinnacle official, the provider subsequently billed and was paid for the correct HCPCS code. However, the provider failed to return the payment for the incorrect claim at that time. As a result, Pinnacle overpaid the provider $32,259.

- One provider billed for 120 units of HCPCS code J0475 although only 6 units were administered. The provider attributed the error to a clerical entry. As a result, Pinnacle paid the provider $18,422 for this drug rather than the appropriate $921, an overpayment of $17,501.

Both providers contacted Pinnacle and refunded the overpayments during our fieldwork.

During CY 2005, the Medicare Multi-Carrier Claims System and the CMS Common Working File did not have sufficient prepayment controls to detect and prevent inappropriate payments resulting from claims for excessive units of service. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their "Medicare Summary Notice" and disclose any provider overpayments.[2] According to a Pinnacle official, during our audit period, the claim processing system included edits to review claims totaling $30,000 or more. However, Pinnacle lowered this limit to $10,000 in April 2007.

RECOMMENDATION

We recommend that Pinnacle ensure that the identified overpayments totaling $49,760 have been recovered in full.

[2]The carrier sends a "Medicare Summary Notice" to the beneficiary after the provider files a claim for Part B service(s). The notice explains the service(s) billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

PINNACLE COMMENTS

In comments on our draft report, Pinnacle agreed with our findings and stated that the two claims in error have been refunded. Pinnacle also indicated that it is working to ensure that these types of claims are monitored for potential overpayments. Pinnacle's comments are included in their entirety as the Appendix.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Pinnacle
BUSINESS SOLUTIONS, INC.

MEDICARE
Part A Intermediary
Part B Carrier

Regina H. Favors
President and Chief Executive Officer
501-210-9036
E-mail: rhfavors@PinnacleBSI.com

May 12, 2009

Mr. Gordon L. Sato
Regional Inspector General for
Audit Services
Office of Audit Services
1100 Commerce, Room 632
Dallas, TX 75242

Re: Report A-06-08-00037

Dear Mr. Sato:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-06-08-00037 entitled, "Review of High-Dollar Payments for Louisiana Medicare Part B Claims Processed By Pinnacle Business Solutions, Inc. for the Period January 1, 2005, through December 31, 2005."

The results of this audit were that 35 claims out of 11.6 million were considered high dollar payments using $10,000 as the criterion. After review of the 35 claims, OIG found that 33 were paid appropriately with two being inappropriate based on one provider erroneously billing for HCPCS code J9015 instead of J9305 and the other provider billing "units" in error. The two claims in error were refunded to PBSI.

PBSI agrees with the findings of the review and is working to ensure that these types of claims are monitored for potential overpayments.

Sincerely,

Regina H. Favors

RF/tb

Cc: CMS Dallas Regional Office