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

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

May 19, 2010

Report Number: A-06-08-00039

Ms. Regina Favors
President and Chief Executive Officer
Pinnacle Business Solutions, Inc.
Medicare Services
515 West Pershing Boulevard
North Little Rock, AR 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, 2006*. We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414 or contact Warren Lundy, Audit Manager, at (405) 605-6183 or through email at Warren.Lundy@oig.hhs.gov. Please refer to report number A-06-08-00039 in all correspondence.

Sincerely,

/Patricia Wheeler/
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

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

Department of Health & 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, 2006

Daniel R. Levinson
Inspector General

April 2010
A-06-08-00039

Office of Inspector General

http://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people 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) 2006, Arkansas Blue Cross and Blue Shield, now doing business as Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 16,800 providers in Louisiana. Pinnacle processed more than 11.4 million Louisiana Part B claims, 57 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 2006 were appropriate.

SUMMARY OF FINDINGS

Of the 57 high-dollar payments that Pinnacle made to Louisiana Part B providers in 2006, 39 claims were appropriate and 7 claims were inappropriate. Pinnacle overpaid five providers a total of $120,277 for the seven claims. We express no opinion on the remaining 11 pharmacy claims, which totaled $433,704, because we could not validate the prescriptions.

Pinnacle made the overpayments because the providers billed for the wrong Healthcare Common Procedure Coding System code or billed for excessive units. In addition, the Medicare claim-processing systems did not have sufficient edits in place during CY 2006 to detect and prevent payments for these types of errors. All but one provider refunded the overpayments during our audit work.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the $120,277 in identified overpayments was recovered and

- determine the allowability of the $433,704 in pharmacy claims and recover any funds found to be unallowable.

PINNACLE COMMENTS

In comments on our draft report, Pinnacle agreed with our findings and indicated that it is working to ensure that these types of claims are monitored to avoid potential overpayments. Pinnacle also indicated that it is researching the claims to ensure that the identified overpayments have been recovered, and that it will determine whether the pharmacy claims are allowable and recover funds if the claims are unallowable. 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) 2006, providers nationwide submitted approximately 818 million claims to carriers. Of these, 9,236 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 2006, Arkansas Blue Cross and Blue Shield, now doing business as Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 16,800 providers in Louisiana. Pinnacle processed more than 11.4 million Louisiana Part B claims, 57 of which resulted in 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 Prescription Drug, Improvement, and 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 2006 were appropriate.

Scope

We identified 60 high-dollar payments that Pinnacle processed during CY 2006. Pinnacle adjusted three payments to less than $10,000 prior to the start of our audit. We reviewed the remaining 57 high-dollar payments, which totaled $1,264,442.

We limited our review of Pinnacle's internal controls to those applicable to the 57 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.

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 audit work;
- 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 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 RECOMMENDATIONS

Of the 57 high-dollar payments that Pinnacle made to Louisiana Part B providers in 2006, 39 claims were appropriate and 7 claims were inappropriate. Pinnacle overpaid five providers a total of $120,277 for the seven claims. We express no opinion on the remaining 11 pharmacy claims, which totaled $433,704, because we could not validate the prescriptions.

Pinnacle made the overpayments because the providers billed for the wrong HCPCS code or billed for excessive units. In addition, the Medicare claim-processing systems did not have sufficient edits in place during CY 2006 to detect and prevent payments for these types of errors.

MEDICARE REQUIREMENTS

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."

INAPPROPRIATE PINNACLE PAYMENTS

Pinnacle overpaid five providers $120,277 for seven claims. Of these seven claims, Pinnacle overpaid one provider $52,246 for three claims:

- The provider billed HCPCS code J9310 for 60 units rather than 6 units, which was the amount administered, because of a keying error. As a result, Pinnacle paid the provider $22,568 for this drug rather than the appropriate amount of $2,257, an overpayment of $20,311.

- The provider billed HCPCS code J9170 for 75 units when it should have billed HCPCS code J9178. As a result, Pinnacle paid the provider $18,161 for this drug rather than the appropriate amount of $1,481, an overpayment of $16,680.

- The provider billed HCPCS code J9170 for 70 units rather than 7 units, which was the amount administered. As a result, Pinnacle paid the provider $16,950 for this drug rather than the appropriate amount of $1,695, an overpayment of $15,255.

One provider billed HCPCS code J9055 for 600 units rather than 60 units, which was the amount administered. The provider indicated that the claim was submitted for payment before its review process was complete because of the cost associated with the drug. As a result, Pinnacle paid the provider $23,934 for this drug rather than the appropriate amount of $2,393, an overpayment of $21,541

One provider billed HCPCS code J9001 for 80 units rather than 8 units, which was the amount administered, because of a data entry error. As a result, Pinnacle paid the provider $23,748 rather than the appropriate amount of $2,375, an overpayment of $21,373.

One provider billed HCPCS code J1745 for 400 units rather than 40 units, which was the amount administered, because of a keying error. As a result, Pinnacle paid the provider $17,037 for this drug rather than the appropriate amount of $1,704, an overpayment of $15,333.

One provider billed HCPCS code J3487 for 80 units when it should have billed HCPCS code J9055 because of a data entry error. As a result, Pinnacle paid the provider $12,975 rather than the appropriate amount of $3,191, an overpayment of $9,784.

All but one provider refunded the overpayments during our audit work.

During CY 2006, 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.

PHARMACY CLAIMS ON WHICH WE EXPRESS NO OPINION

Pinnacle paid one pharmacy $433,704 for 11 claims containing HCPCS code J7190, a hemophilia drug. The pharmacy provider indicated on the claims that a physician had prescribed the drug. The pharmacy provider did not have written prescriptions from the physician, but the owner submitted documentation indicating the prescriptions were phone orders. We contacted the physician listed on the prescription labels, and she said that she did not have records indicating that she had written the prescriptions. However, it was determined that the beneficiary was a hemophiliac and had received the drugs. As a result, we cannot determine the allowability of the 11 claims.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the $120,277 in identified overpayments were recovered and

- determine the allowability of the $433,704 in pharmacy claims and recover any funds found to be unallowable.

[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 indicated that it is working to ensure that these types of claims are monitored to avoid potential overpayments. Pinnacle also indicated that it is researching the claims to ensure that the identified overpayments have been recovered, and that it will determine whether the pharmacy claims are allowable and recover funds if the claims are unallowable. 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

April 5, 2010

Ms. Patricia Wheeler
Regional Inspector General for
Audit Services
Office of Audit Services
1100 Commerce Street, Room 632
Dallas, TX 75242

RE: Report A-06-08-00039

Dear Ms. Wheeler:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-06-08-00039 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, 2006."

The results of this audit indicates that Pinnacle processed more than 11.4 million Louisiana Part B claims during CY 2006, 57 of which resulted in payments of $10,000 or more. Following a review of the 57 claims, the OIG found that 7 claims were overpaid an amount totaling $120,277 because the provider billed for excessive units or used an inappropriate HCPCS code. It was also noted that the OIG could express no opinion specific to the remaining 11 pharmacy claims, totaling $433,704, because they were not able to validate the prescriptions.

PBSI is currently researching these claims to ensure that identified overpayments have been recovered and we will determine the allowability of the pharmacy claims and recover any funds if it is found that these claims are unallowable.

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

Sincerely,
//s//
Regina Favors

RF/tb
Cc: CMS Dallas Regional Office