



September 25, 2008

Report Number: A-06-08-00032

Ms. 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 Arkansas Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc. for the Period January 1, 2004, Through December 31, 2004." 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 principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). 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-06-08-00032 in all correspondence.

Sincerely,

A handwritten signature in black ink that reads "Gordon L. Sato".

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
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 ARKANSAS
MEDICARE PART B CLAIMS
PROCESSED BY PINNACLE
BUSINESS SOLUTIONS, INC. FOR
THE PERIOD JANUARY 1, 2004,
THROUGH DECEMBER 31, 2004**



Daniel R. Levinson
Inspector General

September 2008
A-06-08-00032

Office of Inspector General

<http://oig.hhs.gov>

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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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 and pay Part B claims. These systems can detect certain improper payments during prepayment validation.

During calendar year (CY) 2004, 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 more than 11,000 providers in Arkansas. Pinnacle processed more than 8.2 million Arkansas Part B claims, six 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 Arkansas Part B providers in 2004 were appropriate.

SUMMARY OF FINDINGS

Of the six high-dollar payments that Pinnacle made to providers, four were appropriate. However, Pinnacle overpaid two providers a total of \$16,918 for the remaining two claims. Both providers refunded the overpayments during our fieldwork.

Pinnacle made the overpayments because the providers incorrectly billed excessive units of service or used incorrect Healthcare Common Procedure Coding System codes. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2004 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure the overpayments, totaling \$16,918, have been refunded; and
- ensure that claims with Healthcare Common Procedure Coding System code J2505 contain the correct number of billing units (e.g. claims processing system edits or manual review).

PINNACLE'S COMMENTS

In comments on our draft report, Pinnacle agreed with our findings and stated that the overpayments were refunded in June 2008. Pinnacle also indicated that it is working to ensure that high-dollar claims are monitored for potential overpayments. The comments are summarized in the body of the report and included in their entirety in 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) 2004, providers nationwide submitted approximately 788 million claims to carriers. Of these, 8,938 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 2004, 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 more than 11,000 providers in Arkansas. Pinnacle used the Medicare Multi-Carrier Claims System to process more than 8.2 million Arkansas Part B claims, six 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 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.

¹The Medicare Modernization Act of 2003, Public Law 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 Arkansas Part B providers in 2004 were appropriate.

Scope

We reviewed the six high-dollar payments, totaling \$75,892 that Pinnacle processed during CY 2004.

We limited our review of Pinnacle's internal controls to those applicable to the six 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 May to July 2008.

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 objectives.

FINDING AND RECOMMENDATIONS

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 six high-dollar payments that Pinnacle made to providers, four were appropriate. However, Pinnacle overpaid two providers a total of \$16,918 for the remaining two claims.

- For one claim, a provider mistakenly entered Healthcare Common Procedure Coding System code J9293 rather than the correct code J9263. As a result, Pinnacle paid the provider \$10,606 when it should have paid \$3,718, an overpayment of \$6,888.
- For one claim, a provider claimed 6 units of Healthcare Common Procedure Coding System code J2505 instead of 1 unit. The dosage strength for 1 unit of code J2505 is 6 milligrams. The provider mistakenly billed 6 units for the 6 milligrams used. As a result, Pinnacle paid the provider \$12,036 when it should have paid \$2,006, an overpayment of \$10,030.

The providers attributed the incorrect claims to clerical errors, and refunded the overpayments during our fieldwork.

During CY 2004, 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 these types of erroneous claims. 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

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure the overpayments, totaling \$16,918, have been refunded; and

²The 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.

- ensure that claims with Healthcare Common Procedure Coding System code J2505 contain the correct number of billing units (e.g. claims processing system edits or manual review).

PINNACLE'S COMMENTS

In comments on our draft report, Pinnacle agreed with our findings and stated that the overpayments were refunded in June 2008. Pinnacle also indicated that it is working to ensure that high-dollar claims are monitored for potential overpayments. Pinnacle's comments are included as an appendix.

APPENDIX



MEDICARE
Part A Intermediary
Part B Carrier

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

September 19, 2008

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

Re: Report A-06-08-00032

Dear Mr. Sato:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-06-08-00032 entitled, "Review of High-Dollar Payments for Arkansas Medicare Part B Claims Processed By Pinnacle Business Solutions, Inc. for the Period January 1, 2004, through December 31, 2004."

The results of this audit were that six claims out of 8.2 million were considered high dollar payments using \$10,000 as the criterion. After review of the six claims, OIG found that four were paid appropriately with two being inappropriate based on one provider making a typo in the HCPCS code submitted and the another provider billing "units" in error. The two claims in error were refunded to PBSI during June of 2008.

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

Sincerely,

//s//

RF/tm

Cc: CMS Dallas Regional Office