DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

December 28, 2007

Report Number: A-06-07-00086

Regina Favors
Executive Vice President and Chief Operating 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 Missouri Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc., for the Period January 1, 2003, Through December 31, 2003." 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, within 10 business days after this report is issued, it 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 Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-07-00086 in all correspondence.

Sincerely,

Patricia Wheeler

for Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Mr. Tom Lenz, 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 MISSOURI MEDICARE PART B CLAIMS PROCESSED BY PINNACLE BUSINESS SOLUTIONS, INC., FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

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Office of Inspector General

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Department of Health and Human Services

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS 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) 2003, 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 17,000 providers in Missouri. Pinnacle processed more than 11 million Missouri Part B claims, 59 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 Missouri Part B providers were appropriate.

SUMMARY OF FINDINGS

Forty-six of the 59 high-dollar payments that Pinnacle made to providers were appropriate. However, Pinnacle overpaid providers $65,506 for the remaining 13 payments. Providers stated that they had refunded two of the overpayments, totaling $17,643, prior to our fieldwork; however, Pinnacle had not received the refund for one claim with an overpayment totaling $14,440. Eleven overpayments, totaling $47,863, remained outstanding.

Pinnacle made the overpayments because it made claim processing errors or because providers incorrectly claimed excessive units of service. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2003 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that Pinnacle:

- recover the $47,863 in overpayments identified during our audit,

- process the corrected claim and recover the $14,440 overpayment that the provider stated that it had corrected prior to our audit but Pinnacle had not received,

- review for accuracy claims that had a charged amount equal to the allowed amount, and

- consider using the results of this audit in its provider education activities.

PINNACLE'S COMMENTS

In its comments on our draft report, Pinnacle agreed with the findings and recommendations. Pinnacle's comments are included as an 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) 2003, providers nationwide submitted more than 750 million claims to carriers. Of these, 6,682 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 2003, 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 17,000 providers in Missouri. Pinnacle used the Medicare Multi-Carrier Claims System to process more than 11 million Missouri Part B claims, 59 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.

[1]The 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 Missouri Part B providers were appropriate.

Scope

We reviewed the 59 high-dollar payments, totaling $1,696,082, that Pinnacle processed during CY 2003.

We limited our review of Pinnacle's internal controls to those applicable to the 59 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 to November 2007.

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 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 our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Forty-six of the 59 high-dollar payments that Pinnacle made to providers were appropriate. However, Pinnacle overpaid providers $65,506 for the remaining 13 payments. Providers stated that they had refunded two of the overpayments, totaling $17,643, prior to our fieldwork; however, Pinnacle had not received the refund for one claim with an overpayment totaling $14,440. Eleven overpayments, totaling $47,863, remained outstanding.

Pinnacle made the overpayments because it made claim processing errors or because providers incorrectly claimed excessive units of service. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2003 to detect and prevent payments for these types of erroneous claims.

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 HIGH-DOLLAR PAYMENTS

For one claim the provider incorrectly billed 43 units rather than the correct number of 5 units. The provider stated that the error was discovered during an internal process of reconciling billed charges against the pharmacy's dispensed records. As a result, Pinnacle paid the provider $16,340 for the drug when it should have paid $1,900, an overpayment of $14,440. The provider identified the overpayment prior to our field work and stated that it had sent a $16,340 check and an adjusted claim to Pinnacle in October 2003. However, the provider could not give us a copy of the cancelled check and Pinnacle did not show that it had received the check or the adjusted claim. After obtaining a corrected claim from the provider, Pinnacle will process the claim and send an overpayment letter.

For the remaining 12 claims, Pinnacle made claim processing errors and providers incorrectly claimed excessive units of service:

Pinnacle Claim Processing Errors

- For one claim, Pinnacle priced a drug six cents more than the amount allowed for 41,800 units. As a result, Pinnacle paid $39,053 ($1.18 per unit) when it should have paid $37,453 ($1.12 per unit), an overpayment of $1,600. The provider identified the overpayment but had not refunded the overpayment by the end of our fieldwork.

- For one claim, the provider stated that it had split the claim into two claims due to system limitations in accommodating the large number of units. One of the claims was correct; the

other included an incorrect number of units. As a result, Pinnacle paid the provider $37,855 for the second claim when it should have paid $30,035, an overpayment of $7,820. The provider had not refunded the overpayment by the end of our fieldwork.

- For seven claims submitted by one provider, Pinnacle processed the charged amount as the allowed amount rather than limiting the allowed amount to the correct payment rate.[2] Therefore, Pinnacle incorrectly paid 80 percent of the higher charged amount. As a result, Pinnacle overpaid the provider by $12,348. One of the claims had been adjusted by $3,203 prior to our audit. The provider agreed with the remaining six overpayments but had not refunded the overpayments by the end of our fieldwork.

- For one claim, Pinnacle priced a drug 32 cents more than the amount allowed for 28,770 units. As a result, Pinnacle paid $36,389 ($1.58 per unit) when it should have paid $29,000 ($1.26 per unit), an overpayment of $7,389. The provider had not refunded the overpayment by the end of our fieldwork.

Provider Billing Errors

- For one claim, a provider incorrectly billed the micrograms that were given rather than the international units. As a result, Pinnacle paid the provider $10,632 when it should have paid $2,219, an overpayment of $8,412. Although the provider concurred with the overpayment, it had not refunded the overpayment by the end of our fieldwork.

- For one claim, a provider dispensed and billed a claim for 12 doses even though the prescriber ordered six doses. As a result, Pinnacle paid the provider $26,994. The pharmacist is no longer with the company; therefore, we were not able to obtain an explanation regarding the additional doses that were dispensed. Although the provider agreed to refund $13,497 for six doses, it had not refunded the overpayment by the end of our fieldwork.

Providers attributed the incorrect claims to clerical errors in billing and errors made during claims processing. In addition, during CY 2003, 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.[3]

[2]Since 1998, Medicare payment for drugs has been based on the lower of the actual charge on the Medicare claim or a payment allowance (95 percent of the average wholesale price). In 2003, Medicare required carriers to set the payment allowance based on the Healthcare Common Procedure Coding System code price listed in the CMS Single Drug Pricer file. If a drug is not listed in the Single Drug Pricer file, then the carriers determine the drug's average wholesale price and apply the 95-percent reduction.

[3]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.

RECOMMENDATIONS

We recommend that Pinnacle:

- recover the $47,863 in overpayments identified during our audit,
- process the corrected claim and recover the $14,440 overpayment that the provider stated that it had corrected prior to our audit but Pinnacle had not received,
- review for accuracy claims that had a charged amount equal to the allowed amount, and
- consider using the results of this audit in its provider education activities. .

PINNACLE'S COMMENTS

In its comments on our draft report, Pinnacle agreed with the findings and recommendations. Pinnacle's comments are included as an appendix.

APPENDIX

Part B Carrier

Beneficiaries (1-800-MEDICARE): (800) 633-4227
Provider Automated Line: (877) 567-9230
Providers/Suppliers: (866) 280-6520

Report Number: A-06-07-00086

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

Dear Mr. Sato:

We have reviewed the draft report entitled "Review of High-Dollar Payments for Missouri Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc. for the Period January 1, 2003, Through December 31, 2003" and agree with its findings and recommendations.

For each of the claims noted in the report, we have made adjustments and sent overpayment letters to the providers. We will consider using the results in upcoming provider education.

Sincerely,

/cjb/e

Curtis J. Blair
Vice President of Claims Operations & EDI Coordination
Pinnacle Business Solutions, Inc.

CJB/lad