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-06-07-00085

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 Louisiana 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-06-07-00085 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 LOUISIANA 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

December 2007
A-06-07-00085

Office of Inspector General

http://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 all 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. Specifically, these evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness in departmental programs. To promote impact, the reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, 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 in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

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, 2003, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

December 2007
A-06-07-00085

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC

at http://oig.hhs.gov

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

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 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 18,000 providers in Louisiana. Pinnacle used the Medicare Multi-Carrier Claims System to process Louisiana claims. Pinnacle processed more than 11 million Louisiana Part B claims, 30 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 were appropriate.

SUMMARY OF FINDING

Twenty-nine of the thirty high-dollar payments that Pinnacle made to providers were appropriate. However, Pinnacle overpaid one provider $19,641 for the remaining payment. The provider had not refunded this overpayment by the end of our fieldwork.

Pinnacle made the overpayment because the provider 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 this type of erroneous claim.

RECOMMENDATIONS

We recommend that Pinnacle:

- recover the $19,641 overpayment 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.

TABLE OF CONTENTS

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 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 approximately 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

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 18,000 providers in Louisiana. Pinnacle used the Medicare Multi-Carrier Claims System to process Louisiana claims. Pinnacle processed more than 11 million Louisiana Part B claims, 30 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 Louisiana Part B providers were appropriate.

Scope

We reviewed the 30 high-dollar payments, totaling $540,914, that Pinnacle processed during CY 2003.

We limited our review of Pinnacle's internal controls to those applicable to the 30 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.

FINDING AND RECOMMENDATIONS

Twenty-nine of the thirty high-dollar payments that Pinnacle made to providers were appropriate. However, Pinnacle overpaid one provider $19,641 for the remaining payment. The provider had not yet refunded this overpayment.

Pinnacle made the overpayment because the provider 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 this type of erroneous claim.

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 PAYMENT

For the overpayment still outstanding, totaling $19,641, the provider incorrectly billed Pinnacle for excessive units of service. The provider billed 111 units of service for 1 unit administered. The provider stated that it had mistakenly entered the wrong number of units of service due to a posting (manual keypunch) error. As a result, Pinnacle paid the provider $19,819 for the drug when it should have paid $179, resulting in an overpayment of $19,641.[2] Although the provider agreed that it was overpaid, it had not refunded the overpayment by the end of our fieldwork.

The provider attributed the incorrect claim to clerical errors made by its billing staff. 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]

RECOMMENDATIONS

We recommend that Pinnacle:

- recover the $19,641 overpayment and

[2]The difference is due to rounding.

[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.

- 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-06-07-00085

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 Louisiana 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