DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

March 23, 2009

Report Number: A-06-08-00068

Ms. Melissa Halstead Rhoades
Area Director & Medicare CFO
Financial Management Operations Division
TrailBlazer Health Enterprises, LLC
8330 LBJ Freeway, 11th Floor
Dallas, Texas 75243

Dear Ms. Rhoades:

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 New Mexico and Oklahoma 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 Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00068 in all correspondence.

Sincerely,

Gordon L. Sato

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Ms. 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 NEW MEXICO AND OKLAHOMA MEDICARE PART B CLAIMS PROCESSED BY PINNACLE BUSINESS SOLUTIONS, INC., FOR THE PERIOD JANUARY 1 THROUGH DECEMBER 31, 2005

Daniel R. Levinson
Inspector General

March 2009
A-06-08-00068

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 Act), the Medicare program provides health insurance for people age 65 and over and those who are disabled or have permanent kidney disease. Prior to October 1, 2005, the Centers for Medicare & Medicaid Services (CMS), which administers the program, contracted with carriers to process and pay Medicare Part B claims submitted by physicians and medical suppliers (providers).

During calendar year (CY) 2005, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 19,100 providers in New Mexico and Oklahoma. Pinnacle processed more than 21 million New Mexico and Oklahoma Part B claims, 99 of which resulted in payments of $10,000 or more (high-dollar payments).

As required by the Act, section 1874A, as added by section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS implemented a provision in its Medicare contracting reform efforts that replaces all carriers with Medicare administrative contractors beginning October 1, 2005. As a result, CMS contracted with TrailBlazer Health Enterprises (TrailBlazer) to process New Mexico and Oklahoma Part B claims. Because TrailBlazer assumed responsibility for ensuring that any inappropriately paid CY 2005 claims are corrected, we are issuing our report to TrailBlazer.

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

OBJECTIVE

Our objective was to determine whether Pinnacle's high-dollar Medicare payments to New Mexico and Oklahoma Part B providers were appropriate.

SUMMARY OF FINDING

Of the 99 high-dollar payments that Pinnacle made to providers, 58 were appropriate. Of the remaining 41 payments, Pinnacle overpaid providers for 35 payments totaling $201,218 and adjusted 6 payments to less than $10,000 prior to the start of our audit.

Pinnacle incorrectly paid the providers because it made claim processing errors and because the providers claimed excessive units of service. 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 erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $201,218 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In its comments on our draft report, TrailBlazer agreed with the findings and recommendations. TrailBlazer'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). In addition to processing and paying claims, carriers also reviewed provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process and pay providers' claims, carriers used 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 more than 818 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, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 19,100 providers in New Mexico and Oklahoma. Pinnacle used the Medicare Multi-Carrier Claims System to process more than 22 million New Mexico and Oklahoma Part B claims, 99 of which resulted in high-dollar payments.

TrailBlazer Health Enterprises

As required by section 1874A of the Act, as added by section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, CMS implemented a provision in its Medicare contracting reform efforts that replaces all carriers with Medicare administrative contractors beginning October 1, 2005. As a result, CMS contracted with TrailBlazer Health Enterprises (TrailBlazer) to process New Mexico and Oklahoma Part B claims. Because TrailBlazer assumed responsibility for ensuring that any inappropriately paid CY 2005 claims are corrected, we are issuing our report to TrailBlazer.

"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.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Pinnacle's high-dollar Medicare payments to New Mexico and Oklahoma Part B providers were appropriate.

Scope

We identified 99 high-dollar payments that Pinnacle processed during CY 2005. Pinnacle adjusted six of the payments to less than $10,000 prior to the start of our audit. We reviewed the remaining 93 high-dollar payments, which totaled $1,804,947.

We limited our review of Pinnacle's internal controls to those applicable to the remaining 93 high-dollar 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 audit work from May to December 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 superseded by revised claims or whether payments remained outstanding at the start of our audit;

- 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 and TrailBlazer, including the calculation of any payment errors.

We conducted our 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 99 high-dollar payments that Pinnacle made to providers, 58 were appropriate. Of the remaining 41 payments, Pinnacle overpaid providers for 35 payments totaling $201,218 and adjusted 6 payments to less than $10,000 prior to the start of our audit.

Pinnacle incorrectly paid the providers because it made claim processing errors and because the providers submitted claims with incorrect HCPCS codes or excessive units of service. 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 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

Pinnacle made 22 incorrect payments to providers because of claim processing errors. In addition, Pinnacle made 13 incorrect payments because providers submitted claims with incorrect HCPCS codes or excessive units of service.

Carrier Pricing Errors

Pinnacle incorrectly priced 22 claims.

- For nine claims, Pinnacle incorrectly priced HCPCS code J7190. Pinnacle paid eight claims at $0.78 per unit and one claim at $0.65 per unit; the correct amount for this code was $0.641 per unit. As a result of the errors, Pinnacle overpaid the providers $25,986.

- For five claims, Pinnacle incorrectly priced HCPCS code J7192. In the first quarter of 2005, Pinnacle paid three claims at $1.06 per unit; the correct amount for this code was $1.056 per unit.[1] In the second quarter of 2005, two claims were priced at $1.20 per unit; the correct amount for this code was $1.063 per unit. As a result of the errors, Pinnacle overpaid the provider $3,693.

- For one claim, Pinnacle incorrectly priced HCPCS code J7193 at $1.022 per unit; the correct amount for this code was $0.882 per unit. As a result, Pinnacle overpaid the provider $3,377.

- For three claims, Pinnacle incorrectly priced HCPCS code J7195. In the first quarter of 2005, Pinnacle paid one claim at $2.00 per unit; the correct amount for this code was $0.981 per unit. In the second quarter, Pinnacle paid two claims at $1.12 per unit; the correct amount for this code was $0.982 per unit. As a result of the errors, Pinnacle overpaid the provider $22,123.

- For one claim, Pinnacle incorrectly priced HCPCS code J7198 at $1.381 per unit; the correct amount for this code was $1.242 per unit. As a result, Pinnacle overpaid the provider $2,625.

- For three claims, Pinnacle incorrectly priced HCPCS code Q0187. In the first quarter of 2005, Pinnacle paid one claim at $1,051.45 per unit; the correct amount for this code was $1,211.050 per unit. In the second quarter of 2005, Pinnacle paid two claims at $861.79 per unit; the correct amount for this code was $1,228.440 per unit. As a result of the errors, Pinnacle underpaid the provider $7,856.

Provider Healthcare Common Procedure Coding System Errors

Pinnacle incorrectly paid four claims because the provider used a miscellaneous HCPCS code (J7199) rather than the correct code (J7192) for the drug Helixate FS. Consequently, Pinnacle paid $221,793 when it should have paid $166,071, resulting in an overpayment of $55,722.

Provider Units of Service Errors

Pinnacle incorrectly paid nine claims because providers billed for excessive units of service.

- One provider billed HCPCS code J9170 for 40 units rather than two units, which was the amount provided. As a result, Pinnacle paid $9,396 when it should have paid $470, resulting in an overpayment of $8,926.

- One provider overbilled units of service on two claims on HCPCS code J2505 for six units rather than one unit, which was the amount provided. As a result, Pinnacle paid $20,042 when it should have paid $3,340, resulting in an overpayment of $16,702.

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[1]Effective January 1, 2005, all carriers are required to pay drug claims on the basis of the prices shown in the average sales price files, which CMS updates quarterly.

- One provider billed HCPCS code J7190 for 34,080 units rather than 33,760 units, which was the amount provided. As a result, Pinnacle paid $21,293 when it should have paid $17,312, resulting in an overpayment of $3,981.

- One provider billed HCPCS code J9310 for 68 units rather than seven units, which was the amount provided. As a result, Pinnacle paid $24,802 when it should have paid $2,553, resulting in an overpayment of $22,249.

- One provider billed HCPCS code J9201 for 120 units rather than six units, which was the amount provided. As a result, Pinnacle paid $11,125 when it should have paid $556, resulting in an overpayment of $10,569.

- One provider overbilled units of service on three claims. For one claim, the provider billed HCPCS code J2505 for six units rather than one unit, which was the amount provided. For two claims, the provider billed HCPCS code J9170 for 55 units rather than three units, which was the amount provided. As a result, Pinnacle paid $36,249 when it should have paid $3,128, resulting in an overpayment of $33,121.

Causes of Incorrect Medicare Part B Payments

TrailBlazer agreed that the errors had occurred. The providers that gave a reason attributed the incorrect claims to clerical errors and new employees. Pinnacle incorrectly paid the providers because it made claim processing errors and because the Medicare claim processing systems did not have sufficient edits in place during CY 2005 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the $201,218 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

TRAILBLAZER HEALTH ENTERPRISES COMMENTS

In its comments on our draft report, TrailBlazer agreed with the findings and recommendations. Regarding the first recommendation, TrailBlazer agreed with the recommended recovery amount. TrailBlazer also recovered additional monies related to overpayments. Regarding the second recommendation, TrailBlazer Provider Outreach and Education staff will take actions to address the claim submission errors identified in this audit. TrailBlazer's comments are included in their entirety as the Appendix.

OTHER MATTER

While researching the claims in our audit, three providers identified units of service errors in four claims that were not within the scope of our audit. Three of these claims had 2005 dates of service but were for less than $10,000, and the other claim had a 2007 date of service. For all four claims the providers billed HCPCS code J2505 for six units rather than one unit, which was the correct amount. As a result, Pinnacle paid $40,255 when it should have paid $6,702, resulting in an overpayment of $33,553. The providers submitted corrected claims, which we forwarded to TrailBlazer for processing.

APPENDIX

CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE

March 13, 2009

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

Report Number: A-06-08-00068

Dear Mr. Sato:

We received the February 11, 2009, draft report entitled "Review of High-Dollar Payments for New Mexico and Oklahoma Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc., for the Period January 1 through December 31, 2005." As noted in the draft report, TrailBlazer did not process any of the claims reviewed as part of this report. However, in our role as the Jurisdiction 4 Medicare Administrative Contractor (MAC), TrailBlazer has assumed responsibility for ensuring that any inappropriately paid calendar year 2005 claims identified in this report are corrected.

In the draft report, the OIG recommended that TrailBlazer:

- Recover the $201,218 in overpayments identified during the audit, and
- Consider using the results of this audit in provider education activities.

Please consider the following responses to these recommendations for inclusion in the final report:

Recovery of Overpayments: As a result of this audit, TrailBlazer recovered $204,763 in overpayments. The difference between the overpayment amount indentified in the OIG report and the amount collected by TrailBlazer is related to three claims totaling $3,545, which were identified by TrailBlazer as overpaid while researching and demanding the OIG identified overpayments.

Provider Education Activities: TrailBlazer Provider Outreach and Education staff will take the following actions to address the claim submission errors identified in this audit:

- Develop Web notices.
- Disseminate information via the appropriate TrailBlazer listservs.
- Include in Web-based training sessions, where applicable.
- Include in appropriate face-to-face presentations.
- Share with our Provider Outreach and Education Advisory Group (POE AG) members.

If you have any questions regarding our response, please contact me.

Sincerely,

Melissa Halstead Rhoades

Melissa Halstead Rhoades
Area Director & Medicare CFO

Cc: Virginia Adams, Project Officer for A/B MAC Southern Program Division
Gil R. Glover, President & Chief Operating Officer
Scott J. Manning, Vice President, Financial Mgt. Operations & J4 MAC Project Manager
Kevin Bidwell, Vice President & Compliance Officer