



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

June 12, 2009

Report Number: A-06-08-00031

Mr. Guy Ringle
Senior Vice President, Medicare
WPS Insurance Corporation
1707 West Broadway
Madison, Wisconsin 53707-7927

Dear Mr. Ringle:

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 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.

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-06-08-00031 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:

Ms. Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106
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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
THROUGH DECEMBER 31, 2006**



Daniel R. Levinson
Inspector General

June 2009
A-06-08-00031

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) 2006, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including 19,099 providers in Missouri. Pinnacle processed more than 13 million Missouri Medicare Part B claims, 168 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 Wisconsin Physicians Service Health Insurance Corporation (WPS) to process Missouri Medicare Part B claims. Because WPS assumed responsibility for ensuring that any inappropriately paid CY 2006 claims are corrected, we are issuing our report to WPS.

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 Missouri Part B providers were appropriate.

SUMMARY OF FINDINGS

Of the 168 high-dollar payments that Pinnacle made to providers, 146 were appropriate. Of the remaining 22 payments, Pinnacle incorrectly paid to providers 17 payments totaling \$152,088 and adjusted 5 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 made coding errors and claimed excessive units of service. 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 erroneous claims.

RECOMMENDATIONS

We recommend that WPS:

- recover the \$152,088 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

WISCONSIN PHYSICIANS SERVICE HEALTH INSURANCE CORPORATION COMMENTS

In its comments on our draft report, WPS agreed with the findings and recommendations. WPS'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) 2006, providers nationwide submitted more than 817 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, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including 19,099 providers in Missouri. Pinnacle processed more than 13 million Missouri Medicare Part B claims, 168 of which resulted in high-dollar payments.

Wisconsin Physicians Service Health Insurance Corporation

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 Wisconsin Physicians Service Health Insurance Corporation (WPS) to process Missouri Medicare Part B claims. Because WPS assumed responsibility for ensuring that any inappropriately paid CY 2006 claims are corrected, we are issuing our report to WPS.

“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 Missouri Part B providers were appropriate.

Scope

We identified 168 high-dollar payments that Pinnacle processed during CY 2006. Pinnacle adjusted five of the payments to less than \$10,000 prior to the start of our audit. We reviewed the remaining 163 high-dollar payments, which totaled \$3,492,792.

We limited our review of Pinnacle's internal controls to those applicable to the 163 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 April 2008 to March 2009.

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 WPS, including the calculation of any payment errors.

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 168 high-dollar payments that Pinnacle made to providers, 146 were appropriate. Of the remaining 22 payments, Pinnacle incorrectly paid to providers 17 payments totaling \$152,088 and adjusted 5 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 made coding errors and claimed excessive units of service. 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 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 . . . areas where the trust fund is most at risk, i.e., highest volume and/or highest dollar codes.”

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Pinnacle made 17 incorrect payments, 2 because of claims processing errors and 15 because providers submitted claims with incorrect HCPCS codes and/or excessive units of service.

Carrier Claim Processing Errors

For two claims related to the implantation of neurostimulators, Pinnacle incorrectly processed the surgery codes, 63650 and 64590. When multiple surgery codes and/or units are billed, the first unit of the procedure in the highest payment group is paid at 100 percent; all additional units and/or surgery codes are paid at 50 percent. For one claim, Pinnacle paid 100 percent for the first unit of code 63650 but nothing for the second unit, which should have been paid at the 50-percent rate. For the other claim, Pinnacle paid code 64590 at the 50-percent rate when it should have paid at 100 percent. As a result, Pinnacle paid \$512 when it should have paid \$853, resulting in an underpayment of \$341.

Provider Coding and Units-of-Service Errors

Pinnacle incorrectly paid 15 claims because providers billed the incorrect HCPCS code and/or claimed excessive units of service.

- For 12 claims related to hemophilia blood clotting factors, a provider billed for the drug Hemofil-M using HCPCS code J7192 rather than the correct code, J7190. Pinnacle paid \$411,686 when it should have paid \$261,934, resulting in an overpayment of \$149,752.
- For one claim, the provider billed HCPCS code J9263, a chemotherapy drug, for 600 units rather than 402 units, which was the amount provided. Pinnacle paid \$4,209 when it should have paid \$2,820, resulting in an overpayment of \$1,389.
- For two claims related to spinal surgery, the provider claimed both incorrect HCPCS codes and units of service on multiple line items. As a result, Pinnacle paid \$12,429 when it should have paid \$11,141, resulting in an overpayment of \$1,288.

The provider that gave a reason for its errors attributed them to the complexity of HCPCS coding related to spinal procedures. In addition, the Medicare claims processing systems did not have sufficient edits in place during CY 2006 to detect and prevent payments for these types of erroneous claims. Instead, CMS relied on providers to notify carriers of incorrect payments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider errors.¹

RECOMMENDATIONS

We recommend that WPS:

- recover the \$152,088 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

WISCONSIN PHYSICIANS SERVICE HEALTH INSURANCE CORPORATION COMMENTS

In its comments on our draft report, WPS agreed with the findings and recommendations. WPS’s comments are included in their entirety as the Appendix.

¹The 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.

APPENDIX



Medicare

June 4, 2009

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

Re: OIG Blue Book Audit A-06-08-00031 – May 2009

Dear Mr. Sato:

This letter is in response to the Draft OIG Blue Book titled "Review of High-Dollar Payments for Missouri Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc., for the Period January 1 Through December 31, 2006." In your letter, you requested that comments be provided on each of the recommendations.

WPS assumed responsibility for Eastern Missouri and associated Pinnacle processing activity in 2008. The OIG reviewed 168 high-dollar Part B claims, of which 146 were appropriate. Of the remaining 22 payments, Pinnacle incorrectly paid providers for 17 payments totaling \$152,088 and adjusted five payments to less than \$10,000 prior to the start of the OIG audit.

OIG Recommendations:

- *recover the \$152,088 in overpayments identified during our audit and,*
- *consider using the results of this audit in its provider education activities.*

WPS intends to recoup the overpaid amounts for the 17 claims. We will do this by collecting the overpayments, including abiding by the four-year reopening guidelines. WPS staff will use the results of this audit, where applicable, in our future educational activities.

WPS looks forward to working with you in the completion of this OIG audit of high-dollar payments by Pinnacle. If you have any questions, or need any more information please contact me at 402-351-6915.

Sincerely,


Mark DeFoil
Director, Contract Coordination

cc: Patricia Wheeler, OIG
Suzanne Johnson, CMS
James Underhill, CMS



Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare contractor
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