DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

January 16, 2009

Report Number: A-06-08-00029

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, 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 Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00029 in all correspondence.

Sincerely,

Antonio D. Wilkins

/r/ Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

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

Daniel R. Levinson
Inspector General

January 2009
A-06-08-00029

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. 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) 2004, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 19,000 providers in Missouri. Pinnacle processed more than 12 million Missouri Medicare Part B claims, 102 of which resulted in payments of $10,000 or more (high-dollar payments).

As required by the Social Security 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 2004 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

Seventy of the 102 high-dollar payments that Pinnacle made to seven providers were appropriate. However, Pinnacle overpaid six providers $89,643 for 31 of the 32 remaining payments. Pinnacle adjusted 1 of the 32 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. 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 WPS:

- recover the $89,643 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 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) 2004, providers nationwide submitted more than 787 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, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 19,000 providers in Missouri. Pinnacle used the Medicare Multi-Carrier Claims System to process more than 12 million Missouri Medicare Part B claims, 102 of which resulted in high-dollar payments.

Wisconsin Physicians Service Health Insurance Corporation

As required by section 1874A of the Social Security 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 Wisconsin Physicians Service Health Insurance Corporation (WPS) to process Missouri Medicare Part B claims beginning in June 2008. In addition, WPS assumed the responsibility to ensure that any inappropriately paid CY 2004 claims are corrected. Thus, 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 102 high-dollar payments that Pinnacle processed during CY 2004. Pinnacle adjusted one of the payments to less than $10,000 prior to the start of our audit. We reviewed the remaining 101 high-dollar payments, which totaled $2,689,025.

We limited our review of Pinnacle's internal controls to those applicable to the 101 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 January 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 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 objective. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Seventy of the 102 high-dollar payments that Pinnacle made to seven providers were appropriate. However, Pinnacle overpaid six providers $89,643 for 31 of the 32 remaining payments. Pinnacle adjusted 1 of the 32 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. 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.

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, over utilization 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

Of the 31 payments identified, Pinnacle made nine incorrect payments to providers as a result of claim processing errors. Two of these incorrect payments resulted from incorrect HCPCS pricing, and seven occurred because Pinnacle paid providers for an incorrect number of units. In addition, Pinnacle made 22 incorrect payments as a result of provider coding errors.

Carrier Pricing Errors

Pinnacle incorrectly priced two claims.

- For one claim, Pinnacle priced the first unit of a multiple unit procedure at $256 when it should have paid $512, resulting in an underpayment of $256.

- For one claim, Pinnacle priced 22,000 units of a drug 13 cents more than the amount allowed. Consequently, Pinnacle paid $24,991 ($1.42 per unit) when it should have paid $22,720 ($1.29 per unit), resulting in an overpayment of $2,270.

Carrier Errors in Number of Units Paid

For seven claims from three providers that correctly billed for 6,400 units of a drug (HCPCS code J1785) on each claim, Pinnacle paid for an incorrect number of units.

- For one claim from one provider, Pinnacle paid for 5,760 units, resulting in an underpayment of $1,899.

- For three claims from one provider, Pinnacle paid for 5,760 units for each claim, resulting in a total underpayment of $5,699.

- For three claims from one provider, Pinnacle paid for 6,300 units, 5,760 units, and 5,401 units, respectively, resulting in a total underpayment of $6,227.

Provider Coding Errors

Two providers incorrectly coded 22 claims.

- For seven claims related to hemophilia treatments, one provider incorrectly coded the claims using HCPCS code J7190 when the correct HCPCS code was Q2022. As a result, Pinnacle underpaid the provider $22,546.

- For 15 claims related to hemophilia treatments, one provider incorrectly coded the claims using HCPCS code J7192 when the correct HCPCS code was J7190. As a result, Pinnacle overpaid the provider $124,000.

The providers stated that the claims reviewed did not contain errors; therefore, the providers did not report a cause for the errors. Pinnacle stated that 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 claims for excessive units of service. 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 $89,643 in overpayments identified during our audit and
- consider using the results of this audit in its provider education activities.

[1]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.

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 as the Appendix.

APPENDIX

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

December 23, 2008

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-06-08-00029 – December 2008

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, 2004, through December 31, 2004". In your letter, you requested that comments be provided on each of the recommendations.

WPS assumed responsibility for Eastern Missouri and associated prior Pinnacle's processing activity in June 2008. The OIG reviewed 102 high-dollar Part B claims, of which 70 were appropriate. Pinnacle adjusted one of the payments to less than $10,000 prior to the start of the OIG audit. The results of the review indicated that the remaining 31 payments included overpayments totaling $89,643.

OIG Recommendations:

- *recover the $89,643 in overpayments,*
- *consider using the results of this audit in provider education activities.*

WPS intends to recoup the overpaid amounts for the 31 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 Michelle Routt at 402-351-8293 or me at 402-351-6915.

Sincerely,

Mark DeFoil

Mark DeFoil
Director, Contract Coordination

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

Medicare

cc: Patricia Wheeler, OIG
Nitza Correa, CMS
Suzanne Johnson, CMS