



DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office of Inspector General

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

December 7, 2007

Report Number: A-06-07-00091

Regina Favors
Executive Vice President and Chief Operating Officer
Pinnacle Business Solutions, Inc.
Medicare Services
515 W. 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 Arkansas 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 below.

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 direct them to the HHS action official. Please refer to report number A-06-07-00091 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

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 ARKANSAS
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-06-07-00091

Office of Inspector General

<http://oig.hhs.gov>

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Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
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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 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 11,400 providers in Arkansas. Pinnacle processed approximately 8 million Arkansas Part B claims, 23 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 Arkansas Part B providers were appropriate.

RESULTS OF REVIEW

All 23 of the high-dollar payments, totaling \$304,600 that Pinnacle made to the provider during CY 2003 were appropriate. As a result, this report contains no recommendations.

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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 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, 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 11,400 providers in Arkansas. Pinnacle used the Medicare Multi-Carrier Claims System to process Arkansas claims. Pinnacle processed approximately 8 million Arkansas Part B claims, 23 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.

¹The Medicare Modernization Act of 2003, Pub. L. No. 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 Arkansas Part B providers were appropriate.

Scope

We reviewed the 23 high-dollar payments, totaling \$304,600, that Pinnacle processed during CY 2003.

We limited our review of Pinnacle's internal controls to those applicable to the 23 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 September 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 the provider 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.

We conducted our audit in accordance with generally accepted government auditing standards.

RESULTS OF REVIEW

All 23 of the high-dollar payments, totaling \$304,600 that Pinnacle made to the provider during CY 2003 were appropriate. As a result, this report contains no recommendations.