



February 17, 2009

Report Number: A-06-08-00030

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, 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-06-08-00030 in all correspondence.

Sincerely,

for 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 MISSOURI
MEDICARE PART B CLAIMS
PROCESSED BY PINNACLE
BUSINESS SOLUTIONS, INC., FOR
THE PERIOD JANUARY 1
THROUGH DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

February 2009
A-06-08-00030

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 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. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/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 for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

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 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 19,700 providers in Missouri. Pinnacle processed more than 12 million Missouri Medicare Part B claims, 111 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 2005 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 111 high-dollar payments that Pinnacle made to providers, 76 were appropriate. However, Pinnacle overpaid four providers \$237,405 for the 35 remaining payments.

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 2005 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that WPS:

- recover the \$237,405 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.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Part B Carriers	1
Pinnacle Business Solutions, Inc.	1
Wisconsin Physicians Service Health Insurance Corporation	1
“Medically Unlikely” Edits.....	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	2
FINDINGS AND RECOMMENDATIONS	3
MEDICARE REQUIREMENTS	3
INAPPROPRIATE HIGH-DOLLAR PAYMENTS	3
Provider Coding Errors	3
Carrier Pricing Errors.....	3
RECOMMENDATIONS	4
WISONSIN PHYSICIANS SERVICE HEALTH INSURANCE CORPORATION COMMENTS	4

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 19,700 providers in Missouri. Pinnacle used the Medicare Multi-Carrier Claims System to process more than 12 million Missouri Medicare Part B claims, 111 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 2005 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 and reviewed 111 high-dollar payments, which totaled \$2,651,997, that Pinnacle processed during CY 2005. We limited our review of Pinnacle’s internal controls to those applicable to the 111 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 November 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 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 111 high-dollar payments that Pinnacle made to providers, 76 were appropriate. However, Pinnacle overpaid four providers \$237,405 for the 35 remaining payments.

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 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, 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 35 overpayments identified, Pinnacle made 14 incorrect payments to providers as a result of provider coding errors and 21 additional incorrect payments as a result of claim processing errors.

Provider Coding Errors

For 14 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 \$170,296.

Carrier Pricing Errors

Pinnacle incorrectly priced 21 claims.

- For 13 claims, Pinnacle priced HCPCS code J7192 at \$1.20 or \$1.203 per unit when the correct amount was \$1.063 per unit. As a result, Pinnacle overpaid the providers \$34,033.
- For six claims, Pinnacle priced HCPCS code J7193 at \$1.02 per unit when the correct amount was \$0.882 per unit. As a result, Pinnacle overpaid the provider \$25,740.

- For one claim, Pinnacle priced HCPCS code J9999 at \$24.11 per unit when the correct amount was \$8.438 per unit. As a result, Pinnacle overpaid the provider \$6,269.
- For one claim, Pinnacle priced HCPCS code J7195 at \$1.04 per unit when the correct amount was \$0.982 per unit. As a result, Pinnacle overpaid the provider \$1,068.

In total, Pinnacle overpaid these providers \$67,109.

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 2005, 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 \$237,405 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.

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

February 5, 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-06-08-00030 – January 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, 2005.” In your letter, you requested that comments be provided on each of the recommendations.

WPS assumed responsibility for Eastern Missouri and associated Pinnacle’s processing activity in 2008. The OIG reviewed 111 high-dollar Part B claims, of which 76 were appropriate. The results of their review indicated that the remaining 35 payments included overpayments totaling \$237,405.

OIG Recommendations:

- *recover the \$237,405 in overpayments.*
- *consider using the results of this audit in provider education activities.*

WPS intends to recoup the overpaid amounts for the 35 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
Nitza Correa, CMS
Suzanne Johnson, CMS



Wisconsin Physicians Service Insurance Corporation serving as a CMS Medicare contractor
P.O. Box 1787 • Madison, WI 53701 • Phone 608-221-4711