

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, 2004**



Daniel R. Levinson
Inspector General

February 2009
A-06-08-00035

Office of Inspector General

<http://oig.hhs.gov>

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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.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

February 27, 2009

Report Number: A-06-08-00035

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, 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 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-06-08-00035 in all correspondence.

Sincerely,

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

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 18,500 providers in New Mexico and Oklahoma. Pinnacle processed more than 20 million New Mexico and Oklahoma Part B claims, 179 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 TrailBlazer Health Enterprises (TrailBlazer) to process New Mexico and Oklahoma Part B claims. Because TrailBlazer assumed responsibility for ensuring that any inappropriately paid CY 2004 claims have been 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 FINDINGS

Of the 179 high-dollar payments that Pinnacle made to providers, 142 were appropriate. However, Pinnacle overpaid providers \$125,826 for 33 of the remaining 37 payments. Pinnacle adjusted 4 of the 37 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 2004 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$125,826 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) 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 18,500 providers in New Mexico and Oklahoma. Pinnacle used the Medicare Multi-Carrier Claims System to process more than 20 million New Mexico and Oklahoma Part B claims, 179 of which resulted in high-dollar payments.

TrailBlazer Health Enterprises

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 TrailBlazer Health Enterprises (TrailBlazer) to process New Mexico and Oklahoma Part B claims. Because TrailBlazer assumed responsibility for ensuring that any inappropriately paid CY 2004 claims have been 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 179 high-dollar payments that Pinnacle processed during CY 2004. Pinnacle adjusted four of the payments to less than \$10,000 prior to the start of our audit. We reviewed the remaining 175 high-dollar payments, which totaled \$4,239,605.

We limited our review of Pinnacle’s internal controls to those applicable to the 175 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 October 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 objective. 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 179 high-dollar payments that Pinnacle made to providers, 142 were appropriate. However, Pinnacle overpaid providers \$125,826 for 33 of the remaining 37 payments. Pinnacle adjusted 4 of the 37 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 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, 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 two incorrect payments to providers because of HCPCS pricing errors. In addition, Pinnacle made 31 incorrect payments because of provider errors. Two of these incorrect payments resulted from excessive units of service billed, and 29 of these incorrect payments resulted from incorrect HCPCS coding.

Carrier Pricing Errors

Pinnacle incorrectly priced two claims.

- For one claim, Pinnacle incorrectly paid 80 percent of the charged amount for two units of the drug Fabrazyme (HCPCS miscellaneous code J3490) rather than the correct amount, which was 95 percent of the average wholesale price, or \$7,296.¹ This error resulted in an overpayment of \$6,612.

¹Since 1998, Medicare payment for drugs has been based on the lower of the actual charge on the Medicare claim or a payment allowance (95 percent of the average wholesale price). In 2004, Medicare required carriers to set the payment allowance based on the HCPCS code price listed in the CMS fee schedule “Single Drug Pricer” file. If a drug is not listed in the Single Drug Pricer file, then the carriers determine the drug’s average wholesale price and apply the 95-percent allowance.

- For one claim, Pinnacle priced 45,000 units of the drug Benefix (HCPCS code J7195) at \$0.03 more than the amount allowed. Consequently, Pinnacle paid \$35,280 when it should have paid \$34,200, resulting in an overpayment of \$1,080.

Provider Units-of-Service Errors

Providers billed two claims with excessive units of service.

- For one claim, the provider billed for six units of the drug Pegfilgrastim (HCPCS code J2505) when it should have claimed one unit. As a result, Pinnacle paid \$12,036 when it should have paid \$2,006, resulting in an overpayment of \$10,030.
- For one claim, the provider billed for 80 units of the drug Doxorubicin (HCPCS code J9001) when it should have claimed 8 units. As a result, Pinnacle paid \$22,532 for the drug when it should have paid \$2,253, resulting in an overpayment of \$20,279.

Provider Healthcare Common Procedure Coding System Errors

Providers submitted 29 claims with incorrect HCPCS coding.

- For 22 claims, the provider used a HCPCS miscellaneous code (J7199) rather than the correct code (J7192) for the hemophilia drug Helixate. In addition, the provider billed for excessive units on two of the claims. Consequently, Pinnacle paid \$1,029,884 when it should have paid \$958,926, resulting in an overpayment of \$70,958.
- For one claim, the provider submitted HCPCS miscellaneous code (J7199) rather than the correct code (J7198) for the hemophilia drug FEIBA VH anti-inhibitor. This error resulted in an underpayment of \$1,451.
- For one claim, the provider billed HCPCS code J0475 when it should have billed HCPCS code J0585 for Botox. The provider identified this mistake when we requested information concerning the claim. Pinnacle paid the provider \$15,625 when it should not have paid the claim, resulting in an overpayment of \$15,625.
- For two claims, the provider billed HCPCS code J7193 when it should have billed HCPCS code J7195 for the hemophilia drug Benefix. As a result, Pinnacle paid \$32,614 when it should have paid \$27,664, resulting in an overpayment of \$4,950.
- For three claims, the provider billed HCPCS code J7198 when it should have billed HCPCS code Q0187 for the hemophilia drug Factor VII Recombinate. Using the incorrect HCPCS code resulted in a change in the number of units that should have been claimed. As a result, Pinnacle overpaid one claim by \$210 and another claim by \$414 and underpaid one claim by \$2,881.

Causes of Incorrect Medicare Part B Payments

TrailBlazer agreed that the errors had occurred and has begun adjusting the claims. The providers that gave a reason attributed the incorrect claims to clerical errors. 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 2004 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that TrailBlazer:

- recover the \$125,826 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 interest on overpayments and a duplicate payment. Regarding the second recommendation, TrailBlazer agreed that the provider community would benefit from education and will develop an online job aid. In addition, TrailBlazer stated that it had implemented an edit in June 2005 to suspend claims with billed amounts greater than \$25,000 and the medically unlikely edits CMS required beginning in January 2007. TrailBlazer's comments are included in their entirety as the Appendix.

APPENDIX



MEDICARE

February 19, 2009

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

Report Number: A-06-08-00035

Dear Mr. Sato:

We received the December 19, 2008, 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, 2004." 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 2004 claims identified in this report are corrected.

In the draft report, the OIG recommended that TrailBlazer:

- Recover the \$125,826 in overpayments identified during the audit; and
- Consider using the results of this audit in its 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 \$130,196.74 in overpayments and refunded \$4,331.53 to underpaid providers. The difference between the \$125,826.01 identified by the OIG and collections net of underpayments made by TrailBlazer, \$125,865.21, is a \$39.20 duplicate payment identified and recovered by TrailBlazer. Additionally, TrailBlazer collected \$348.61 in interest on the identified overpayments.

Correction of Underpayments: The report identified two underpayments totaling \$4,331.53. TrailBlazer adjusted the claims and issued additional payments of \$4,331.53 to the providers in September 2008.

Provider Education Activities: TrailBlazer believes the provider community would benefit from broad education regarding proper claims submission for drugs and biologicals and the importance of submitting the correct HCPCS code. TrailBlazer will develop an online job aid to include coding tips and promote the job aid through TrailBlazer listservs and Web notices and applicable provider contacts.

TrailBlazer Health Enterprises, LLC
Executive Center III • 8330 LBJ Freeway • Dallas, TX 75243-1213
A Medicare Administrative Contractor



Gordon L. Sato
February 19, 2009
Page 2 of 2

Claims Processing: In June 2005, TrailBlazer implemented an edit to suspend claims with billed amounts in excess of \$25,000. These high dollar suspensions are resolved by lead claims staff. Designated high dollar claims are logged and reviewed for reasonableness. If inaccuracy or fraud is suspected, or trends are detected, claims are referred to management or medical staff for further review. Any potential fraud that is identified is immediately referred to the Payment Safeguard Contractor or Zone Program Integrity Contractor.

In addition, beginning January, 2007, CMS quarterly releases for "Medically Unlikely Edits" (MUE) are implemented as scheduled. MUEs based on unit of service are developed by CMS and issued in a quarterly release for implementation by the MAC. These edits are similar in nature to the findings in six of the seven claim errors identified in the audit report. The edit tests claim lines for the same beneficiary, procedure code, date of service, and billing provider against a specified number of units of service. The entire claim line is denied when the units of service billed exceed the CMS specified parameter. A sample of claims resolutions are audited monthly for each claim analyst.

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

Sincerely,

/s/ 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