



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

January 14, 2010

Report Number: A-06-08-00036

Ms. Regina Favors
President and Chief Executive Officer
Pinnacle Business Solutions, Inc.
Medicare Services
515 West 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 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414 or contact Warren Lundy, Audit Manager, at (405) 605-6183 or through email at Warren.Lundy@oig.hhs.gov. Please refer to report number A-06-08-00036 in all correspondence.

Sincerely,

/Patricia Wheeler/
Regional Inspector General
for Audit Services

Enclosure

cc:

Ms. Theresa Baxley, ASQ CQA
Internal Controls & Performance Analyst
Internal Controls & Communications
Pinnacle Business Solutions, Inc.
515 West Pershing Boulevard
North Little Rock, Arkansas 72114-2147

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
rokcmora@cms.hhs.gov

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 THROUGH
DECEMBER 31, 2005**



Daniel R. Levinson
Inspector General

January 2010
A-06-08-00036

Notices

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

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site.

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. 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) 2005, 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 more than 10,000 providers in Arkansas. Pinnacle processed more than 8.7 million Arkansas Part B claims, 11 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 in 2005 were appropriate.

SUMMARY OF FINDINGS

All 11 high-dollar payments that Pinnacle made to providers were inappropriate. Pinnacle overpaid five providers a total of \$51,037 for the claims. Pinnacle made some of the overpayments because the providers incorrectly billed:

- for excessive units of service,
- for the wrong Healthcare Common Procedure Coding System (HCPCS) code, or
- based on invoice pricing.

Pinnacle also made overpayments because it incorrectly calculated claim payments or processed the wrong number of units of service. 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.

All of the providers refunded the overpayments during our audit work.

RECOMMENDATIONS

We recommend that Pinnacle ensure that:

- the \$51,037 in overpayments has been refunded;
- claims with HCPCS code J3490 are priced and paid correctly (e.g., perform periodic manual reviews); and
- claims with HCPCS codes J2505, J9010, and J9035 contain the correct number of billing units (e.g., implement claims processing system edits or perform periodic manual reviews).

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In written comments on our draft report, Pinnacle agreed with our findings and stated that all of the overpayments had been refunded. Pinnacle also indicated that it is working to ensure that these types of claims are monitored for potential overpayments. Pinnacle's comments are included in their entirety as the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

Based on Pinnacle's response to our draft report, we modified the final report to indicate that the providers had refunded the overpayments.

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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 and pay 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) 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, 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 more than 10,000 providers in Arkansas. Pinnacle used the Medicare Multi-Carrier Claims System to process more than 8.7 million Arkansas Part B claims, 11 of which resulted in 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 (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.

¹The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P. 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 in 2005 were appropriate.

Scope

We reviewed the 11 high-dollar payments, totaling \$129,208, that Pinnacle processed during CY 2005.

We limited our review of Pinnacle's internal controls to those applicable to the 11 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 May 2008 to September 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/or superseded by revised claims or whether payments remained outstanding at the time of our audit work;
- 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, including the calculation of any overpayments, with Pinnacle.

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

All 11 high-dollar payments that Pinnacle made to providers were inappropriate. Pinnacle overpaid five providers a total of \$51,037 for the claims. Pinnacle made some of the overpayments because the providers incorrectly billed:

- for excessive units of service,
- for the wrong HCPCS code, or
- based on invoice pricing.

Pinnacle also made overpayments because it incorrectly calculated claim payments or processed the wrong number of units of service. 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, 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 PINNACLE PAYMENTS

Pinnacle overpaid five providers \$51,037 for 11 claims.

For six claims, the provider used the invoice price (the amount the drug wholesaler charges providers for drugs) to bill HCPCS code J3490. Pinnacle paid the provider for the invoice amount rather than the “Red Book”² amount as required. As a result, Pinnacle paid the provider \$72,514 for the six claims when it should have paid \$66,576, an overpayment of \$5,938.

For two claims, the provider billed HCPCS code J9010 for 30 units rather than 3 units, which was the amount provided to the beneficiary. The provider attributed the error to a keying mistake. As a result, Pinnacle paid the provider \$24,557 for the two claims when it should have paid \$2,456, an overpayment of \$22,101.

For one claim, Pinnacle incorrectly processed the number of units the provider billed to HCPCS code J9035. The provider submitted a claim for 90 units of J9035, but Pinnacle

²The “Red Book” contains the average wholesale price of virtually every drug approved by the Food and Drug Administration.

paid for 901 units. As a result, Pinnacle paid the provider \$10,440 when it should have paid \$3,904, an overpayment of \$6,536.

For one claim, the provider mistakenly billed HCPCS code J2505 for six units rather than one unit because the dosage strength for one unit of code J2505 was 6 milligrams. As a result, Pinnacle paid the provider \$10,021 when it should have paid \$1,670, an overpayment of \$8,351.

For one claim, the provider billed HCPCS code J9010 for 24 units rather than HCPCS code J9206 for 12 units, which was the drug and number of units provided to the beneficiary. The provider attributed the error to human oversight. As a result, Pinnacle paid the provider \$9,330 when it should have paid \$1,218, an overpayment of \$8,112.

All of the providers refunded the overpayments during our audit work.

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 these types of erroneous claims. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider overpayments.³

RECOMMENDATIONS

We recommend that Pinnacle ensure that:

- the \$51,037 in overpayments has been refunded;
- claims with HCPCS code J3490 are priced and paid correctly (e.g., perform periodic manual reviews); and
- claims with HCPCS codes J2505, J9010, and J9035 contain the correct number of billing units (e.g., implement claims processing system edits or perform periodic manual reviews).

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In written comments on our draft report, Pinnacle agreed with our findings and stated that all of the overpayments had been refunded. Pinnacle also indicated that it is working to ensure that these types of claims are monitored for potential overpayments. Pinnacle’s comments are included in their entirety as the Appendix.

³The 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.

OFFICE OF INSPECTOR GENERAL RESPONSE

Based on Pinnacle's response to our draft report, we modified the final report to indicate that the providers had refunded the overpayments.

APPENDIX



MEDICARE
Part A Intermediary
Part B Carrier

Regina H. Favors
President and Chief Executive Officer
501-210-9036
E-mail: rhfavors@PinnacleBSI.com

November 23, 2009

Ms. Patricia Wheeler
Regional Inspector General for
Audit Services
Office of Audit Services
1100 Commerce Street, Room 632
Dallas, TX 75242

RE: Report A-06-08-00036

Dear Ms. Wheeler:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-06-08-00036 entitled, "Review of High-Dollar Payments for Arkansas Medicare Part B Claims Processed By Pinnacle Business Solutions, Inc. for the Period January 1, 2005, through December 31, 2005."

The results of this audit were that 11 claims out of 8.7 million were considered high dollar payments using \$10,000 as the criterion. After review of the 11 claims, OIG found that all 11 were paid inappropriately because the providers either incorrectly billed excessive units of service, used the wrong HCPCS code or billed based on invoice pricing. All 11 of the high-dollar overpayments have been refunded to PBSI.

PBSI agrees with the findings of the review and is working to ensure that these types of claims are monitored to avoid potential overpayments.

Sincerely,

//s//

RF/tb

Cc: CMS Dallas Regional Office