



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

June 23, 2009

Report Number: A-06-08-00038

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, 2006." 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 Warren Lundy, Audit Manager, at (405) 605-6183 or through e-mail at Warren.Lundy@oig.hhs.gov. Please refer to report number A-06-08-00038 in all correspondence.

Sincerely,

Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Nanette Foster Reilly, Consortium Administrator
Consortium for Financial Management & Fee for Service Operations (CFMFFSO)
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
THROUGH DECEMBER 31, 2006**



Daniel R. Levinson
Inspector General

June 2009
A-06-08-00038

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. 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) 2006, 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, 15 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 2006 were appropriate.

SUMMARY OF FINDINGS

Of the 15 high-dollar payments that Pinnacle made to providers, 14 were appropriate. Pinnacle overpaid one provider \$18,786 for the remaining claim. The provider refunded the overpayment during our fieldwork.

Pinnacle made the overpayment because the provider incorrectly billed excessive units of service for Healthcare Common Procedure Coding System code J9310. In addition, the Medicare claim processing systems did not have sufficient edits in place during CY 2006 to detect and prevent payments for these types of erroneous claims.

RECOMMENDATIONS

We recommend that Pinnacle ensure that:

- the overpayment of \$18,786 has been refunded and
- CY 2006 claims with Healthcare Common Procedure Coding System code J9310 totaling less than \$10,000 contain the correct number of billing units (e.g., claims processing system edits or manual review).

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In comments on our draft report, Pinnacle agreed with our findings and stated that the one claim in error was 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.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Medicare Part B Carriers	1
Pinnacle Business Solutions, Inc.	1
“Medically Unlikely” Edits.....	1
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology	2
FINDINGS AND RECOMMENDATIONS	3
INAPPROPRIATE PINNACLE PAYMENT	3
RECOMMENDATIONS	3
PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS	3
APPENDIX	
PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS	

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) 2006, providers nationwide submitted approximately 818 million claims to carriers. Of these, 9,236 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 2006, 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, 15 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 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. 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 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 2006 were appropriate.

Scope

We reviewed the 15 high-dollar payments, totaling \$208,337, that Pinnacle processed during CY 2006.

We limited our review of Pinnacle's internal controls to those applicable to the 15 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 May 2008 to February 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 fieldwork;
- contacted providers to determine whether high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and
- discussed 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

INAPPROPRIATE PINNACLE PAYMENT

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.”

Of the 15 high-dollar payments that Pinnacle made to providers, 14 were appropriate. Pinnacle overpaid one provider \$18,786 for the remaining claim.

Regarding the overpaid claim, the provider billed for 56 units of Healthcare Common Procedure Coding System code J9310 rather than 6 units, which was the amount provided to the beneficiary. The provider billed the excessive units because of an error converting milligrams to billing units. One billing unit of code J9310 equals 100 milligrams. The beneficiary received 560 milligrams; thus, the provider should have billed only 6 units. As a result, Pinnacle paid the provider \$21,041 for code J9310 when it should have paid \$2,255, an overpayment of \$18,786. The provider refunded the overpayment during our fieldwork.

During CY 2006, the Medicare Multi-Carrier Claims System and CMS’s 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.²

RECOMMENDATIONS

We recommend that Pinnacle ensure that:

- the overpayment of \$18,786 has been refunded and
- CY 2006 claims with Healthcare Common Procedure Coding System code J9310 totaling less than \$10,000 contain the correct number of billing units (e.g., claims processing system edits or manual review).

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In comments on our draft report, Pinnacle agreed with our findings and stated that the one claim in error was refunded. Pinnacle also indicated that it is working to ensure that these types of

²The 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.

claims are monitored for potential overpayments. Pinnacle's comments are included in their entirety as the Appendix.

APPENDIX



MEDICARE
Part A Intermediary
Part B Carrier

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

May 12, 2009

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

Re: Report A-06-08-00038

Dear Mr. Sato:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-06-08-00038 entitled, "Review of High-Dollar Payments for Arkansas Medicare Part B Claims Processed By Pinnacle Business Solutions, Inc. for the Period January 1, 2006, through December 31, 2006."

The results of this audit were that 15 claims out of 8.7 million were considered high dollar payments using \$10,000 as the criterion. After review of the 15 claims, OIG found that 14 were paid appropriately with one being inappropriate based on the provider billing excessive units of service for HCPCS J9310. The claim in error was refunded to PBSI.

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

Sincerely,

A handwritten signature in cursive script that reads "Regina H. Favors".

RF/tb

Cc: CMS Dallas Regional Office