



April 8, 2009

Report Number: A-06-08-00071

Ms. Melissa Halstead Rhoades  
Area Director & Medicare CFO  
Financial Management Operations Division  
TrailBlazer Health Enterprises, LLC  
8330 LBJ Freeway, 11<sup>th</sup> 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, 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 Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at [Trish.Wheeler@oig.hhs.gov](mailto:Trish.Wheeler@oig.hhs.gov). Please refer to report number A-06-08-00071 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 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106  
[rokcmora@cms.hhs.gov](mailto:rokcmora@cms.hhs.gov)

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, 2006**

Daniel R. Levinson  
Inspector General



April 2009  
A-06-08-00071

# ***Office of Inspector General***

<http://oig.hhs.gov>

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# *Notices*

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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 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) 2006, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 20,900 providers in New Mexico and Oklahoma. Pinnacle processed more than 22 million New Mexico and Oklahoma Part B claims, 159 of which resulted in payments of \$10,000 or more (high-dollar payments).

As required by the 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 2006 claims are 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 159 high-dollar payments that Pinnacle made to providers, 145 were appropriate. Of the remaining 14 payments, Pinnacle overpaid providers for 12 payments totaling \$86,035 and adjusted 2 payments to less than \$10,000 prior to the start of our audit. Some of the providers sent reimbursement payments totaling \$39,818 to TrailBlazer after the start of our audit, which reduced the outstanding overpayment amount to \$46,217.

Pinnacle incorrectly paid the providers because it made claim processing errors and because the providers claimed excessive units of service. 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 TrailBlazer:

- ensure that the outstanding overpayments, totaling \$46,217, have been recovered 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) 2006, providers nationwide submitted more than 817 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, Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare Part B carrier for providers in several States, including about 20,900 providers in New Mexico and Oklahoma. Pinnacle processed more than 22 million New Mexico and Oklahoma Part B claims, 159 of which resulted in high-dollar payments.

#### TrailBlazer Health Enterprises

As required by the 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 2006 claims are 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 159 high-dollar payments that Pinnacle processed during CY 2006. Pinnacle adjusted two of the payments to less than \$10,000 prior to the start of our audit. We reviewed the remaining 157 high-dollar payments, which totaled \$2,946,067.

We limited our review of Pinnacle’s internal controls to those applicable to the remaining 157 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 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 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 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 159 high-dollar payments that Pinnacle made to providers, 145 were appropriate. Of the remaining 14 payments, Pinnacle overpaid providers for 12 payments totaling \$86,035 and adjusted 2 payments to less than \$10,000 prior to the start of our audit. Some of the providers sent reimbursement payments totaling \$39,818 to TrailBlazer after the start of our audit, which reduced the outstanding overpayment amount left to be paid to \$46,217.

Pinnacle incorrectly paid the providers because it made claim processing errors and because the providers claimed excessive units of service. 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.

### **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 claim processing errors. In addition, Pinnacle made 10 incorrect payments because providers submitted claims with excessive units of service.

#### **Carrier Pricing Errors**

Pinnacle incorrectly priced HCPCS code J7190 on one claim. Pinnacle paid 72 percent of the allowable amount when it should have paid 80 percent. As a result, Pinnacle underpaid the provider \$3,444.

#### **Carrier Units-of-Service Errors**

Pinnacle paid one claim based on the wrong number of units. The provider claimed 45,360 units but was paid for 43,116 units of HCPCS code J7190. As a result, Pinnacle underpaid the provider \$1,077.

## **Provider Units-of-Service Errors**

Pinnacle incorrectly paid 10 claims because providers billed for excessive units of service.

- One provider billed HCPCS code J9010 for 30 units rather than 3 units, which was the amount provided. As a result, Pinnacle paid \$12,738 when it should have paid \$1,274, resulting in an overpayment of \$11,464.
- One provider billed HCPCS code J2505 for six units rather than one unit, which was the amount provided. As a result, Pinnacle paid \$10,383 when it should have paid \$1,726, resulting in an overpayment of \$8,657.
- One provider overbilled units of service on four claims. For one claim, the provider billed HCPCS code J2505 for six units rather than one unit, which was the amount provided. For three claims, the provider billed HCPCS code J9010 for 30 units rather than 3 units, which was the amount provided. As a result, Pinnacle paid \$47,622 when it should have paid \$5,361, resulting in an overpayment of \$42,261.
- One provider billed HCPCS code J9035 for 200 units rather than 20 units, which was the amount provided. As a result, Pinnacle paid \$9,103 when it should have paid \$910, resulting in an overpayment of \$8,193.
- One provider billed HCPCS code J9310 for 27 units rather than 21 units, which was the amount provided. As a result, Pinnacle paid \$10,144 when it should have paid \$7,890, resulting in an overpayment of \$2,254.
- One provider overstated units of service for HCPCS code J9310 on two claims. The provider billed for 30 units and 32 units, respectively, rather than 8 units on each claim, which was the amount provided. As a result, Pinnacle paid \$23,892 when it should have paid \$6,166, resulting in an overpayment of \$17,726.

## **Causes of Incorrect Medicare Part B Payments**

TrailBlazer agreed that the errors had occurred. The providers that gave a reason attributed the incorrect claims to clerical errors, miscalculations in the number of units billed, and errors regarding services that were rendered on separate days. 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 2006 to detect and prevent payments for these types of erroneous claims.

## **RECOMMENDATIONS**

We recommend that TrailBlazer:

- ensure that the outstanding overpayments, totaling \$46,217, have been recovered 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. Regarding the second recommendation, TrailBlazer's provider outreach and education staff will take actions to address the claim submission errors identified in the audit. TrailBlazer's comments are included in their entirety as the Appendix.

# **APPENDIX**



MEDICARE

March 27, 2009

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

Report Number: A-06-08-00071

Dear Mr. Sato:

We received the February 27, 2009, 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, 2006." 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 2006 claims identified in this report are corrected.

In the draft report, the OIG recommended that TrailBlazer:

- Ensure that the outstanding overpayments, totaling \$46,217, have been recovered, and
- Consider using the results of this audit in 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 \$50,738 in overpayments. The difference between the overpayment amount identified in the OIG report and the amount collected by TrailBlazer is related to underpayments totaling \$4,521, which were identified during the audit and have been refunded to the providers. The net overpayment collected by TrailBlazer is \$46,217.

**Provider Education Activities:** TrailBlazer Provider Outreach and Education staff will take the following actions to address the claim submission errors identified in this audit:

- Develop Web notices.
- Disseminate information via the appropriate TrailBlazer listservs.
- Include in Web-based training sessions, where applicable.
- Include in appropriate face-to-face presentations.
- Share with our Provider Outreach and Education Advisory Group (POE AG) members.

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



Gordon L. Sato  
March 27, 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,



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