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AUG 1 8 2008

Report Number: A-01-08-00512

Ms. Regina Favors
Executive Vice President of Operations
Pinnacle Business Solutions, Inc.
515 West Pershing Blvd.
North Little Rock, Arkansas 72114

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 Medicare Outpatient Claims Processed by Pinnacle Business Solutions, Inc., for Calendar Years 2004 Through 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 principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5). 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 Leah Scott, Audit Manager, at (617) 565-2679 or through e-mail at Leah.Scott@oig.hhs.gov. Please refer to report number A-01-08-00512 in all correspondence.

Sincerely,

Michael J. Armstrong
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 MEDICARE OUTPATIENT CLAIMS PROCESSED BY PINNACLE BUSINESS SOLUTIONS, INC., FOR CALENDAR YEARS 2004 THROUGH 2006

Daniel R. Levinson
Inspector General

August 2008
A-01-08-00512

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:

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THIS REPORT IS AVAILABLE TO THE PUBLIC
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Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, Office of Inspector General reports generally are made available to the public to the extent the information is not subject to exemptions in the Act (45 CFR part 5).

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 fiscal intermediaries to process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File to process claims.

Federal guidance provides that intermediaries should maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. In addition, Medicare guidance requires hospitals to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes.

During calendar years (CY) 2004–2006, Pinnacle Business Solutions, Inc. (Pinnacle), was the fiscal intermediary for Rhode Island. Pinnacle processed over 1 million outpatient claims in Rhode Island during this period, 6 of which resulted in payments of $50,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether high-dollar Medicare payments that Pinnacle made to a Rhode Island hospital for outpatient services were appropriate.

SUMMARY OF FINDING

Of the six high-dollar payments that Pinnacle made for outpatient services for CYs 2004–2006, two were appropriate. The remaining four payments were for claims with provider billing errors that resulted in overpayments totaling $141,386.

Pinnacle made the overpayments because it did not have prepayment or postpayment controls in place during CYs 2004 and 2005 to identify erroneous claims. In addition, neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2004 and 2005 to detect and prevent excessive payments.

RECOMMENDATIONS

We recommend that Pinnacle:

- recover the $141,386 in overpayments and
- ensure that all high-dollar claims are identified and reviewed.

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In comments on our draft report, Pinnacle agreed with our finding and recommendations. Pinnacle'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 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 Fiscal Intermediaries

CMS contracts with fiscal intermediaries to, among other things, process and pay Medicare Part B claims submitted by hospital outpatient departments. The intermediaries' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that intermediaries must maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments. In addition, Medicare guidance requires hospitals to submit accurate claims for outpatient services using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes.

To process hospitals' outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. The Common Working File can detect certain improper payments during prepayment validation.

In calendar years (CY) 2004–2006, fiscal intermediaries processed and paid over 418 million outpatient claims, 1,317 of which resulted in payments of $50,000 or more (high-dollar payments).

Pinnacle Business Solutions, Inc.

During CYs 2004–2006, Pinnacle Business Solutions, Inc. (Pinnacle), was the fiscal intermediary in Rhode Island. Pinnacle processed over 1 million outpatient claims during this period, 6 of which resulted in high-dollar payments, all made to the same hospital.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that Pinnacle made to a Rhode Island hospital for outpatient services were appropriate.

Scope

We reviewed the six high-dollar payments totaling approximately $340,000 for outpatient claims from one Rhode Island hospital that Pinnacle processed during CYs 2004–2006. We limited our review of Pinnacle's internal controls to those applicable to the six payments 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 through May 2008. Our audit work included contacting Pinnacle, located in North Little Rock, Arkansas, and the hospital in Providence, Rhode Island, that received the high-dollar payments.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient claims with high-dollar payments;
- reviewed available Common Working File 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 time of our fieldwork;
- contacted the hospital that received the high-dollar payments to determine whether the information on the claims was correct and supported and, if not, why the claims were incorrect and whether the hospital agreed that refunds were appropriate.

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 finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

Of the six high-dollar payments that Pinnacle made for outpatient services for CYs 2004–2006, two were appropriate. The remaining four payments were for claims with provider billing errors that resulted in overpayments totaling $141,386.

Pinnacle made the overpayments because it did not have prepayment or postpayment controls in place during CYs 2004 and 2005 to identify erroneous claims. In addition, neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place during CYs 2004 and 2005 to detect and prevent excessive payments.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, Public Law No. 99-509, requires hospitals to report claims for outpatient services using HCPCS codes. CMS's

"Medicare Claims Processing Manual," Publication No. 100-04, Chapter 4, section 20.4, states: "The definition of service units . . . is the number of times the service or procedure being reported was performed." In addition, Chapter 1, section 80.3.2.2, of this manual states: "In order to be processed correctly and promptly, a bill must be completed accurately."

CMS's "Medicare Program Integrity Manual," Publication No. 100-08, Chapter 3, section 11.1, states: "For Medicare to consider coverage and payment for any item or service, the information submitted by the supplier or provider (e.g., claims and CMNs [certificates of medical necessity]) must be corroborated by the documentation in the patient's medical records that Medicare coverage criteria have been met."

Section 3700 of the "Medicare Intermediary Manual" states: "It is essential that you [the fiscal intermediary] maintain adequate internal controls over Title XVIII [Medicare] automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments."

INAPPROPRIATE HIGH-DOLLAR PAYMENTS

Pinnacle made overpayments to one Rhode Island hospital for four high-dollar claims for CYs 2004−2006. For three of these claims that were processed during CYs 2004 and 2005, Pinnacle overpaid the hospital $141,366 because the hospital claimed excessive units of service. For example, the hospital incorrectly billed 354 units of the drug Oxaliplatin rather than 26 units because the hospital did not report the correct unit of measure for the drug. As a result, Pinnacle paid the hospital $29,086 for this drug when it should have paid $2,197, an overpayment of $26,889.

For the remaining overpaid claim, which was processed during CY 2006, Pinnacle overpaid the hospital $20 because the hospital claimed a service that was not supported by medical record documentation. This $20 overpayment was part of a $63,000 claim, the rest of which was paid correctly.

The hospital attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent the errors. The hospital agreed that it had received overpayments that it should refund to the Medicare Program.

CAUSES OF OVERPAYMENTS

During CYs 2004 and 2005, Pinnacle did not have prepayment or postpayment controls to identify erroneous claims, and the Common Working File lacked prepayment edits to detect and prevent excessive payments. In effect, CMS relied on hospitals to notify the fiscal intermediaries of excessive payments and on beneficiaries to review their "Medicare Summary Notice" and disclose any overpayments.[1]

[1]The fiscal intermediary sends a "Medicare Summary Notice" to the beneficiary after the hospital 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.

FISCAL INTERMEDIARY PREPAYMENT EDIT

On January 3, 2006, during our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend high-dollar outpatient claims until intermediaries have conducted a prepayment review to determine the legitimacy of the claims. Pinnacle implemented an edit on January 3, 2006, that suspends claims with reimbursement amounts of $50,000 or more. Pinnacle then contacts the providers who submitted the suspended claims to ensure that the charges are correct. The results of our review offer evidence that the edit is effective: of the two high-dollar payments totaling approximately $126,000 that Pinnacle made in Rhode Island for 2006, only $20 was incorrectly paid.

RECOMMENDATIONS

We recommend that Pinnacle:

- recover the $141,386 in overpayments and

- ensure that all high-dollar claims are identified and reviewed.

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In comments on our draft report, Pinnacle agreed with our finding and recommendations. 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

August 8, 2008

Mr. Michael J. Armstrong
Regional Inspector General for
Audit Services
Office of Audit Services
John F. Kennedy Federal Building
Room 2425
Boston, MA 02203

Re: Report A-01-08-00512

Dear Mr. Armstrong:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-01-08-00512 entitled, "Review of High-Dollar Payments for Medicare Outpatient Claims Processed By Pinnacle Business Solutions, Inc. for Calendar Years 2004 – 2006."

The results of this audit of our Rhode Island outpatient claims were that 6 claims (all from the same hospital) out of one million were considered high dollar payments using $50,000 as the criterion. After review of the 6 claims, OIG found that 2 were paid appropriately with three being inappropriate based on providers billing "units" in error and one having a $20 service in error. The hospital agreed that the claims were in error and agree to refund the amounts in error. Additionally, our data analysis area will utilize the $50,000 criteria to determine additional high dollar claims that may have been paid after the OIG review period of 2004 – 2006. Additionally, special "medically unlikely" edits were installed in January of 2007 to reduce the likelihood of inappropriate payments based on threshold levels of units for selected codes which could incur high unit levels and consequently, high dollar payments.

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

Sincerely,

Regina H. Favors

RF/tm

cc: CMS Dallas Regional Office