DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

December 28, 2007

Report Number: A-06-07-00057

Regina Favors
Executive Vice President and Chief Operating 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 Medicare Part A Claims Processed by Pinnacle Business Solutions, Inc. for the Period January 1, 2003, Through December 31, 2003." 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, within 10 business days after this report is issued, it 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 Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-07-00057 in all correspondence.

Sincerely,

Patricia Wheeler

for Gordon L. Sato
Regional Inspector General
for Audit Services

Enclosure

HHS Action Official:

Mr. Tom Lenz, 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 PART A CLAIMS PROCESSED BY PINNACLE BUSINESS SOLUTIONS, INC. FOR THE PERIOD JANUARY 1, 2003, THROUGH DECEMBER 31, 2003

Daniel R. Levinson
Inspector General

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Office of Inspector General

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Department of Health and Human Services

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and paying providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Providers generate the claims for inpatient and outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (the PPS). Under the PPS, claims are paid a predetermined amount based on a patient's placement into a specific diagnosis-related group and an additional amount, known as an outlier, for stays that have extraordinarily high costs. Outpatient hospital services are paid based on the number of times that the service or procedure being reported was performed. Hospitals are required to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS).

To process providers' inpatient and outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

Pinnacle Business Solutions, Inc. (Pinnacle), is a Medicare Part A fiscal intermediary serving Medicare providers in Arkansas and Rhode Island. For Arkansas inpatient claims with dates of service in calendar year (CY) 2003, Pinnacle processed eight inpatient claims that had payments of $200,000 or more (high-dollar payments). For Arkansas outpatient claims with dates of service in calendar year (CY) 2003, Pinnacle processed one outpatient claim that had a payment of $50,000 or more (high-dollar payments).

OBJECTIVE

Our objective was to determine whether Pinnacle's high-dollar Medicare payments to Arkansas Part A providers for inpatient and outpatient services were appropriate.

SUMMARY OF FINDINGS

Of the eight high-dollar inpatient payments and one high-dollar outpatient payment that Pinnacle made to providers, one inpatient payment was appropriate. However, Pinnacle overpaid providers $79,037 for six inpatient claims and $257,862 for one outpatient claim. We were not able to determine the error amount for one inpatient claim because it had not been adjusted by the end of our field work.

The providers attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent the incorrect billing of units of service. In addition, Pinnacle made the incorrect payments because providers submitted incorrect claims that neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the $336,899 in overpayments have been recovered,
- follow up with the provider on the one claim that had not been adjusted,
- use the results of this audit in its provider education activities, and
- identify and recover any additional overpayments made for high-dollar Part A inpatient claims paid after CY 2003.

PINNACLE'S COMMENTS

In its comments on our draft report, Pinnacle agreed with the findings and recommendations. Pinnacle's comments are included as an appendix.

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INTRODUCTION

BACKGROUND

Fiscal Intermediary Responsibilities

The Centers for Medicare & Medicaid Services (CMS) contracts with fiscal intermediaries to administer Medicare Part A claims. The intermediaries' responsibilities include determining costs and reimbursement amounts, maintaining records, establishing controls, safeguarding against fraud and abuse, conducting reviews and audits, and making payments to providers for services rendered. Federal guidance requires intermediaries to maintain adequate internal controls to prevent increased program costs and erroneous or delayed payments.

Claims for Inpatient and Outpatient Services

Providers generate the claims for inpatient and outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately for the services and procedures provided. Inpatient hospital services are paid based on the Medicare prospective payment system (the PPS). In accordance with the PPS, fiscal intermediaries reimburse hospitals a predetermined amount depending on the illness and its classification under a diagnosis-related group (DRG). Inpatient stays that are extremely long or have extraordinarily high costs are eligible for an additional amount called an outlier payment.

The Medicare fiscal intermediary identifies outlier cases by comparing the estimated costs of a case to a DRG-specific fixed-loss threshold. Because hospitals cannot calculate the costs of cases individually, the fiscal intermediary uses the Medicare charges the hospital reported on its claim to estimate the cost of a case. Inaccurately reporting charges can lead to excessive outlier payments.

Outpatient hospital services are paid based on the number of times the service or procedure being reported was performed. Hospitals are required to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS).

To process providers' inpatient and outpatient claims, the intermediaries use the Fiscal Intermediary Standard System and CMS's Common Working File. These systems can detect certain improper payments when processing claims for prepayment validation.

In calendar year (CY) 2003, providers submitted approximately 13.5 million inpatient claims and 131.5 million outpatient claims nationwide. Of the 13.5 million inpatient claims, only 3,128 claims resulted in payments of $200,000 (high-dollar payments). Of the 131.5 million outpatient claims, only 254 claims resulted in payment of $50,000 or more (high-dollar payments). We considered such claims to be at high risk for overpayment.

Pinnacle

Arkansas Blue Cross Blue Shield, now doing business as Pinnacle Business Solutions, Inc. (Pinnacle), is a Medicare Part A fiscal intermediary serving Medicare providers in Arkansas and

Rhode Island. In CY 2003, Pinnacle processed 160,857 in Arkansas Part A inpatient claims that had payments of approximately $973.8 million and 1.1 million CY 2003 outpatient claims that had payments of approximately $184.4 million. Of these claims, Pinnacle processed 8 inpatient claims and 1 outpatient claim that had high-dollar payments.

The Social Security Act's definition of "provider of services" encompasses hospitals, skilled nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, renal dialysis facilities, and hospice programs. However, all providers with high-dollar claims processed by Pinnacle were hospitals; thus, the term "provider" as used in the remainder of this report refers to hospitals.

New Fiscal Intermediary Prepayment Edit

On January 3, 2006, after the end of our audit period, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends outpatient claims of $50,000 or more and requires intermediaries to contact providers to determine the legitimacy of the claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Pinnacle's high-dollar Medicare payments to Arkansas Part A providers for inpatient and outpatient services were appropriate.

Scope

We reviewed the eight high-dollar inpatient claims totaling $2,162,752 and one high-dollar outpatient claim totaling $259,993 processed during CY 2003.

We limited our review of Pinnacle's internal control structure to those controls applicable to the nine 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 a 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.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- used CMS's National Claims History file to identify Medicare Part A inpatient and outpatient claims with high-dollar payments;

- reviewed available Common Working File claims histories for claims with high-dollar payments to determine whether the claims had been canceled and superseded by revised claims or whether the payments remained outstanding at the time of our fieldwork;

- contacted providers to determine whether the high-dollar claims were billed correctly and, if not, why the claims were billed incorrectly; and

- coordinated our claim review with Pinnacle.

We conducted our audit in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Of the eight high-dollar inpatient payments and one high-dollar outpatient payment that Pinnacle made to providers, one inpatient payment was appropriate. However, Pinnacle overpaid providers $79,037 for six inpatient claims and $257,862 for one outpatient claim. We were not able to determine the error amount for one inpatient claim because it had not been adjusted by the end of our field work.

The providers attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent incorrect billing of units of service. In addition, Pinnacle made these incorrect payments because providers submitted incorrect claims that neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect.

FEDERAL REQUIREMENTS

Inpatient Claims

The Social Security Amendments of 1983 (Public Law 98-21) provided for the establishment of the PPS. In accordance with Medicare's PPS for inpatient acute care hospitals, reimbursement to hospitals for inpatient services furnished to beneficiaries is a predetermined amount, known as a DRG payment.

Section 1886(d)(5)(A) of the Social Security Act requires that Medicare pay hospitals an outlier payment in addition to the basic DRG amount to protect the hospital from incurring large financial losses due to unusually expensive cases. Furthermore, the "Hospital Manual," section 462, states: "In order to be paid correctly and promptly, a bill must be completed accurately."

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."

Outpatient Claims

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986 requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). Section 3627.8(C) of the "Medicare Intermediary Manual" states: "The definition of service units is being revised for hospital outpatient services where HCPCS code reporting is required. A unit is being redefined as the 'number of times the service or procedure being reported was performed.'" Furthermore, the "Hospital Manual," section 462, states: "In order to be paid correctly and promptly, a bill must be completed accurately.

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 INPATIENT HIGH-DOLLAR PAYMENTS

Seven high-dollar claims (one which has not been revised), totaling $79,037 in net overpayments, resulted in the following inappropriate payments:

- For two claims from one provider, the provider performed a detailed charge level review of each claim. The review identified undercharges (items documented in the medical record as provided to the patient but not identified as billed on the claim form) and overcharges (items identified as billed on the claim form but not documented in the patient's medical record). For one of the claims, the provider has not submitted a corrected claim. For the other claim, Pinnacle paid the provider $228,192 when it should have paid $226,416, an overpayment of $1,776.

- For one claim, the provider performed a detailed charge level review of the claim. The review disclosed discrepancies in certain portions in the billing of pharmacy, laboratory, radiology, physical therapy, speech-language, and pathology services. As a result, Pinnacle paid the provider $218,040 when it should have paid $211,788, an overpayment of $6,252.

- For three claims from one provider, the provider performed a detailed charge level review of each claim. The review identified overcharges and undercharges. The changes and/or corrections related to inadvertent charging errors made by automated systems, to incomplete or to missing documentation, and to the posting of charges for items or services for which the provider could not find the documentation. The charging errors related largely to pharmacy items, supplies, and laboratory and respiratory services. As a result, Pinnacle paid the provider $886,168 when it should have paid $837,827, an overpayment of $48,341.

- For one claim, the provider initially stated that there was no error in the claim. After we requested that the provider review several line items that we identified as excessive in our review of the detailed bill, the provider identified overcharges and undercharges. The

charging errors were due to a keying error in the unit count, duplicate charges and charges that were inadvertently left off the detailed bill. As a result, Pinnacle paid the provider $204,803 when it should have paid $182,135, an overpayment of $22,668.

INAPPROPRIATE OUTPATIENT HIGH-DOLLAR PAYMENTS

For one high-dollar claim totaling $259,992, the provider incorrectly billed the units of service. The provider billed 6,000 units of service when it should have billed 60 units of service. The provider reported that in 2003, when this claim was billed and paid, it did not have audits and daily reports in place to identify large amounts of charges/units on a single account. As a result, Pinnacle should have paid the provider only $2,130, an overpayment of $257,862.

CAUSES OF INCORRECT PAYMENTS

The providers attributed the incorrect claims to clerical errors or to billing systems that could not detect and prevent the incorrect billing of units of service. In addition, Pinnacle made these incorrect payments because providers submitted incorrect claims that neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2003 to detect. Medicare relied on providers to notify the intermediaries of excessive payments.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the $336,899 in overpayments have been recovered,
- follow up with the provider on the one claim that had not been adjusted,
- use the results of this audit in its provider education activities, and
- identify and recover any additional overpayments made for high-dollar Part A inpatient and outpatient claims paid after CY 2003.

PINNACLE'S COMMENTS

In its comments on our draft report, Pinnacle agreed with the findings and recommendations. Pinnacle's comments are included as an appendix.

APPENDIX

Part B Carrier

Beneficiaries (1-800-MEDICARE): (800) 633-4227
Provider Automated Line: (877) 567-9230
Providers/Suppliers: (866) 280-6520

December 27, 2007

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

RE: Report Number A-06-07-00087

Dear Mr. Sato:

We have reviewed the draft report entitled "Review of High-Dollar Payments for Medicare Part A Claims Processed by Pinnacle Business Solutions, Inc., for the Period January 1,2003, Through December 31, 2003" and agree with its findings and recommendations.

For each of the claims noted in the report, we have made adjustments and sent overpayment letters to the providers. We will consider using the results in upcoming provider education.

Sincerely,

/cjb/e

Curtis J. Blair
Vice President of Claims Operations & EDI Coordination
Pinnacle Business Solutions, Inc.

CJB/lad