



Office of Audit Services  
Region I  
John F. Kennedy Federal Building  
Boston, MA 02203  
(617) 565-2684

JUL 14 2008

Report Number: A-01-08-00504

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

Dear Ms. Favors:

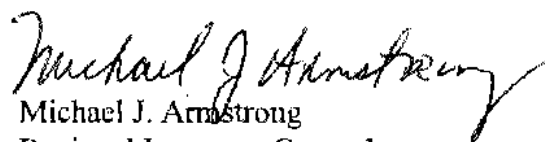
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of High-Dollar Payments for Rhode Island Medicare Part B Claims Processed by Pinnacle Business Solutions, Inc., for Calendar Years 2004 Through 2006." We will forward a 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](mailto:Leah.Scott@oig.hhs.gov). Please refer to report number A-01-08-00504 in all correspondence.

Sincerely,

  
Michael J. Armstrong  
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  
Centers for Medicare & Medicaid Services  
601 East 12<sup>th</sup> Street, Room 235  
Kansas City, Missouri 64106

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF HIGH-DOLLAR  
PAYMENTS FOR RHODE ISLAND  
MEDICARE PART B CLAIMS  
PROCESSED BY PINNACLE  
BUSINESS SOLUTIONS, INC., FOR  
CALENDAR YEARS  
2004 THROUGH 2006**



Daniel R. Levinson  
Inspector General

July 2008  
A-01-08-00504

# ***Office of Inspector General***

<http://oig.hhs.gov>

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## **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 Part B claims. These systems can detect certain improper payments during prepayment validation.

Pinnacle Business Solutions, Inc. (Pinnacle) is the Medicare Part B carrier for providers in several States, including about 4,500 providers in Rhode Island. During calendar years (CY) 2004–2006, Pinnacle processed more than 7 million Part B claims in Rhode Island, 45 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 Part B providers in Rhode Island were appropriate.

### **SUMMARY OF FINDING**

Forty-two of the 45 high-dollar payments that Pinnacle made to providers in Rhode Island were appropriate. However, Pinnacle overpaid providers \$52,029 for the remaining three payments. Providers refunded two of the overpayments, totaling \$33,975, before our fieldwork. One overpayment of \$18,054 remained outstanding.

Pinnacle made the overpayments because the three providers incorrectly claimed excessive units of service. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004–2006 to detect and prevent payments for these types of erroneous claims.

### **RECOMMENDATIONS**

We recommend that Pinnacle:

- recover the \$18,054 overpayment and
- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2006.

## **PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS**

In its written comments on our draft report, Pinnacle agreed with our findings. 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 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

Before 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).<sup>1</sup> Carriers also review provider records to ensure proper payment and assist in applying safeguards against unnecessary utilization of services. To process 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 years (CY) 2004–2006, providers nationwide submitted approximately 2.4 billion claims to carriers. Of these, 31,576 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.

Pinnacle Business Solutions, Inc., (Pinnacle) is the Medicare Part B carrier for providers in several States, including about 4,500 providers in Rhode Island. During CYs 2004–2006, Pinnacle used the Medicare Multi-Carrier Claims System to process more than 7 million Part B claims in Rhode Island, 45 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.

### OBJECTIVE, SCOPE, AND METHODOLOGY

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<sup>1</sup>The Medicare Modernization Act of 2003, Pub. 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**

Our objective was to determine whether Pinnacle's high-dollar Medicare payments to Part B providers in Rhode Island were appropriate.

## **Scope**

We reviewed the 45 high-dollar payments, totaling \$894,833, to Rhode Island providers that Pinnacle processed during CYs 2004–2006.

We limited our review of Pinnacle's internal controls to those applicable to the 45 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 December 2007 to April 2008.

## **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 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;
- analyzed Common Working File data for canceled claims for which revised claims had been submitted to determine whether the initial claims were overpayments;
- 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.

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 objective. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

## **FINDING AND RECOMMENDATIONS**

Forty-two of the 45 high-dollar payments that Pinnacle made to providers in Rhode Island were appropriate. However, Pinnacle overpaid providers \$52,029 for the remaining three payments. Providers refunded two of the overpayments, totaling \$33,975, before our fieldwork. One overpayment of \$18,054 remained outstanding.

Pinnacle made the overpayments because the three providers incorrectly claimed excessive units of service. In addition, the Medicare claim processing systems did not have sufficient edits in place during CYs 2004–2006 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**

For all three overpayments, totaling \$52,029, providers incorrectly billed Pinnacle for excessive units of service:

- One provider billed 366 units of service (subsequent nursing facility care, per day) for 1 unit delivered. The provider stated that it had mistakenly entered the date of service range as 1 year rather than 1 day. As a result, Pinnacle overpaid the provider \$15,274. Pinnacle should have made no payment to the provider for this claim because the beneficiary’s outstanding deductible was greater than the cost of one unit of service. The provider identified and refunded the overpayment before our fieldwork.
- One provider billed 70 units of service (doses of a chemotherapy drug) for 7 units delivered. The provider stated that it had mistakenly entered the wrong number of units of service because of a data entry error. As a result, Pinnacle paid the provider \$20,779 when it should have paid \$2,078, an overpayment of \$18,701. The provider identified and refunded the overpayment before our fieldwork.
- One provider billed 10 units of service (doses of a drug) for 1 unit delivered. The provider stated that it had mistakenly entered the wrong number of units of service because of a data entry error. As a result, Pinnacle paid the provider \$20,060 when it should have paid \$2,006, an overpayment of \$18,054. Although the provider agreed that it was overpaid, it had not refunded the overpayment at the time of our fieldwork.

Providers attributed the incorrect claims to clerical errors made by their billing staff. In addition, during CYs 2004–2006, 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 claims for excessive units of service. Instead, CMS relied on providers to notify carriers of overpayments and on beneficiaries to review their “Medicare Summary Notice” and disclose any provider overpayments.<sup>2</sup>

## **RECOMMENDATIONS**

We recommend that Pinnacle:

- recover the \$18,054 overpayment and
- consider identifying and recovering any additional overpayments made for high-dollar Part B claims paid after CY 2006.

## **PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS**

In its written comments on our draft report, Pinnacle agreed with our findings. Pinnacle’s comments are included in their entirety as the Appendix.

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<sup>2</sup>The 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.

# **APPENDIX**



**MEDICARE**  
Part A Intermediary  
Part B Carrier

Regina H. Favors  
Executive Vice President/Chief Operating Officer  
501-210-9036  
E-mail: [rhfavors@PinnacleBSI.com](mailto:rhfavors@PinnacleBSI.com)

July 2, 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-01-08-00504

Dear Mr. Armstrong:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-01-08-00504 entitled, "Review of High-Dollar Payments for Rhode Island Medicare Part B Claims Processed By Pinnacle Business Solutions, Inc. for Calendar Years 2004 – 2006."

The results of this audit were that 45 claims out of seven million were considered high dollar payments using \$10,000 as the criterion. After review of the 45 claims, OIG found that 42 were paid appropriately with three being inappropriate based on providers billing "units" in error. Two of the three claims in error were refunded to PBSI prior to the OIG review. The remaining claim will be collected. Additionally, our data analysis area will utilize the \$10,000 criteria to determine additional high dollar claims that may have been paid after the OIG review period of 2004 – 2006. However, 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