DEPARTMENT OF HEALTH AND HUMAN SERVICES Office of Inspector General

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

Report Number: A-06-08-00042 January 13, 2009

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 Medicare Outpatient Services Processed by Pinnacle Business Solutions, Inc., During Calendar Year 2005." 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 Patricia Wheeler, Audit Manager, at (214) 767-6325 or through e-mail at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-08-00042 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 12th Street, Room 235
Kansas City, Missouri 64106
rokcmora@cms.hhs.gov

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE OUTPATIENT SERVICES PROCESSED BY PINNACLE BUSINESS SOLUTIONS, INC., DURING CALENDAR YEAR 2005

Daniel R. Levinson
Inspector General

January 2009
A-06-08-00042

Office of Inspector General

http://oig.hhs.gov

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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. The Common Working File can detect certain improper payments during prepayment validation.

Medicare guidance requires hospitals to claim outpatient services using the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and to report units of service as the number of times that a service or procedure was performed.

During our audit period, calendar year (CY) 2005, Pinnacle Business Solutions, Inc. (Pinnacle), was the fiscal intermediary serving Medicare providers in Arkansas. During CY 2005, Pinnacle processed approximately 1.3 million outpatient claims, 4 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 Arkansas providers for outpatient services were appropriate.

SUMMARY OF FINDINGS

All four high-dollar payments were not appropriate. Three of the claims were adjusted prior to the start of our audit. For the remaining claim, Pinnacle overpaid the provider $46,078. Contrary to Federal guidance, the provider billed the incorrect HCPCS code. Pinnacle made the overpayment because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2005 to detect billing errors related to this type of error.

RECOMMENDATIONS

We recommend that Pinnacle:

- inform us of the status of the recovery of the $46,078 overpayment,
- review the provider's claims for the procedure code identified in this report and correct any claims found in error, and
- use the results of this audit in its provider education activities.

PINNACLE COMMENTS

In written comments on our draft report, Pinnacle agreed with the findings and said 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.

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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.

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 year (CY) 2005, fiscal intermediaries processed and paid approximately 141 million outpatient claims, 401 of which resulted in payments of $50,000 or more (high-dollar payments). We considered such claims to be at high risk for overpayment.

Claims for Outpatient Services

Medicare guidance requires hospitals to submit accurate claims for outpatient services. Hospitals should use the appropriate Healthcare Common Procedure Coding System (HCPCS) codes and report units of service as the number of times that a service or procedure was performed.

Pinnacle Business Solutions, Inc.

During our audit period, CY 2005, Pinnacle Business Solutions, Inc. (Pinnacle), was the fiscal intermediary serving Medicare providers in Arkansas. During CY 2005, Pinnacle processed approximately 1.3 million outpatient claims, 4 of which resulted in high-dollar payments.

OBJECTIVE, SCOPE, AND METHODLOGY

Objective

Our objective was to determine whether high-dollar Medicare payments that Pinnacle made to Arkansas providers for outpatient services were appropriate.

Scope

We reviewed the four high-dollar payments for outpatient claims that Pinnacle processed during CY 2005.

We limited our review of Pinnacle's internal controls to those controls applicable to the four 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.

We conducted our audit work from January through November 2008.

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 claims histories for claims with high-dollar payments to determine whether the claims had been cancelled and superseded by revised claims or whether payments remained outstanding at the time of our audit;
- contacted the provider that received the high-dollar payments to determine whether the information on the claim was correct 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 objectives. We believe that the evidence obtained provides a reasonable basis for our finding and conclusions based on our audit objective.

FINDING AND RECOMMENDATIONS

All four high-dollar payments were not appropriate. Three of the claims were adjusted prior to the start of our audit. For the remaining claim, Pinnacle overpaid the provider $46,078. Contrary to Federal guidance, the provider billed the incorrect HCPCS code. Pinnacle made the overpayment because neither the Fiscal Intermediary Standard System nor the Common Working File had sufficient edits in place in CY 2005 to detect billing errors related to this type of error.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. 99-509, requires hospitals to report claims for outpatient services using Healthcare Common Procedure Coding System (HCPCS) codes. CMS's "Medicare Claims Processing Manual," Publication No. 100-04, chapter 4, section 20.4, states that the number 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 the manual states: "To be processed 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 HIGH-DOLLAR PAYMENT

Pinnacle made the overpayment because the provider had assigned an incorrect HCPCS code (J9010) to the intravenous immune globulin therapy given to a patient. The correct HCPCS code should have been Q9941. As a result, Pinnacle paid the provider $53,412 when it should have paid $7,334, resulting in an overpayment of $46,078.

CAUSES OF INCORRECT PAYMENT

The provider agreed that the overpayment had occurred and attributed the incorrect payment to billing an incorrect HCPCS code. In addition, during CY 2005, Pinnacle did not have prepayment or postpayment controls to identify overpayments at the claim level, and the Common Working File prepayment editing process lacked edits to detect and prevent excessive payments. In effect, CMS relied on providers to notify the intermediaries of excessive payments and on beneficiaries to review their "Explanation of Medicare Benefits" and disclose any overpayments.[1]

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. The edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

[1]The fiscal intermediary sends an "Explanation of Medicare Benefits" 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.

RECOMMENDATIONS

We recommend that Pinnacle:

- inform us of the status of the recovery of the $46,078 overpayment,
- review the provider's claims for the procedure code identified in this report and correct any claims found in error, and
- use the results of this audit in its provider education activities.

PINNACLE COMMENTS

In written comments on our draft report, Pinnacle agreed with the findings and said that it is working to ensure that these types of claims are monitored for potential overpayments. Pinnacle stated that it (1) had adjusted the claim in our finding in December 2008, (2) will determine whether there were other high-dollar claims involving code J9010 that may have been paid after the audit period, and (3) will use the information in provider training materials. Pinnacle's comments are included in their entirety as the Appendix.

APPENDIX

MEDICARE
Part A Intermediary
Part B Carrier

Regina H. Favors
President & CEO
501-210-9036
E-mail: rhfavors@PinnacleBSI.com

December 24, 2008

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

Re: Report A-06-08-00042

Dear Mr. Sato:

This letter is Pinnacle Business Solutions, Inc.'s (PBSI) response to the Draft OIG Report A-06-08-00042 entitled, "Review of High-Dollar Payments for Medicare Outpatient Claims Processed By Pinnacle Business Solutions, Inc. During Calendar Year 2005."

The results of this audit of our Arkansas outpatient claims were that 4 claims (all from the same hospital) out of 1.3 million were considered high dollar payments using $50,000 as the criterion. After review of the 4 claims, OIG found that all 4 were paid inappropriately. Three of the claims were adjusted prior to the start of the audit. The fourth claim was adjusted in December of 2008.

A special job will be run to determine if there were other high dollar claims involving code J9010 that may have been paid after the OIG review period of 2005 and prior to 2007. 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. The information from this OIG audit will be used in the development of our training materials for providers.

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 Favors/by L. Milligan

RF/tm

Cc: CMS Dallas Regional Office