Department of Health & Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HIGH-DOLLAR PAYMENTS FOR MEDICARE OUTPATIENT CLAIMS PROCESSED BY PINNACLE BUSINESS SOLUTIONS, INC., FOR THE PERIOD JANUARY 1, 2007, THROUGH DECEMBER 31, 2008

Daniel R. Levinson
Inspector General

(October 2010)
A-06-10-00034

Notices

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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.

DEPARTMENT OF HEALTH & HUMAN SERVICES **Office of Inspector General**

Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

October 12, 2010

Report Number: A-06-10-00034

Ms. Regina Favors
President and Chief Executive Officer
Pinnacle Business Solutions, Inc.
Medicare Services
515 West Pershing Boulevard
North Little Rock, AR 72114

Dear Ms. Favors:

Enclosed is the U.S. Department of Health & 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 the Period January 1, 2007, Through December 31, 2008*. 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.

Section 8L of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG Web site. Accordingly, this report will be posted at http://oig.hhs.gov.

If you have any questions or comments about this report, please do not hesitate to call me at (214) 767-8414 or contact Michelle Richards, Audit Manager, at (214) 767-9202 or through email at Michelle.Richards@oig.hhs.gov. Please refer to report number A-06-10-00034 in all correspondence.

Sincerely,

/Patricia Wheeler/
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 (CFMFFSO)
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

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 providers to bill accurately and to report units of service as the number of times that the service or procedure was performed.

Pinnacle Business Solutions, Inc. (Pinnacle), is a Medicare fiscal intermediary. During calendar years 2007 and 2008, Pinnacle served 537 Medicare providers in Arkansas and processed approximately 2.5 million outpatient claims, one of which resulted in a payment of $50,000 or more (high-dollar payment).

Beginning January 3, 2006, 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.

OBJECTIVE

Our objective was to determine whether the high-dollar Medicare payment that Pinnacle made to a provider for outpatient services was appropriate.

SUMMARY OF FINDING

The high-dollar payment that Pinnacle made to a provider for outpatient services was not appropriate. Pinnacle overpaid the provider $21,726. Contrary to Federal guidance, the provider inappropriately overstated the units of a drug administered to the patient. In addition, Pinnacle's process for determining the accuracy of claims suspended by the high-dollar edit was not adequate because Pinnacle relied on the provider to make the determination.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the $21,726 was refunded, and

- use the results of this audit in its ongoing provider education activities.

PINNACLE COMMENTS

In response to our draft report, Pinnacle reported that the entire $21,726 was recovered. Pinnacle's comments are included in their entirety in 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 requires intermediaries to maintain adequate internal controls over automatic data processing systems to prevent increased program costs and erroneous or delayed payments.

To process providers' 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 when processing claims for prepayment validation.

In calendar years (CY) 2007 and 2008, fiscal intermediaries processed and paid more than 282 million outpatient claims, 617 of which resulted in payments of $50,000 or more (high-dollar payment). We consider such claims to be at high risk for overpayment.

Claims for Outpatient Services

Providers generate the claims for outpatient services provided to Medicare beneficiaries. Medicare guidance requires providers to bill accurately and to report units of service as the number of times that the service or procedure was performed.

Fiscal intermediaries use 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.

Pinnacle Business Solutions, Inc.

Pinnacle Business Solutions, Inc. (Pinnacle), is a Medicare fiscal intermediary. During CY 2007 and 2008, Pinnacle served 537 Medicare providers in Arkansas and processed approximately 2.5 million outpatient claims, one of which resulted in a high-dollar payment.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether the high-dollar Medicare payment that Pinnacle made to a provider for outpatient services was appropriate.

Scope

We reviewed one outpatient high-dollar payment that Pinnacle processed during CY 2008. We limited our review of Pinnacle's internal controls to those applicable to the one payment 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 in the claim obtained from the National Claims History file, but we did not assess the completeness of the file.

We conducted our audit work from November 2009 through April 2010.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- used CMS's National Claims History file to identify Medicare outpatient claims with high-dollar payments;
- contacted the provider that received the high-dollar payment to determine whether the information on the claim was correct and, if not, why the claim was incorrect and whether the provider agreed that a refund was appropriate; and
- coordinated our 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

The high-dollar payment that Pinnacle made to a provider for outpatient services was not appropriate. Pinnacle overpaid the provider $21,726. Contrary to Federal guidance, the provider inappropriately overstated the units of a drug administered to the patient. In addition, Pinnacle's process for determining the accuracy of claims suspended by the high-dollar edit was not adequate because Pinnacle relied on the provider to make the determination.

FEDERAL REQUIREMENTS

Section 9343(g) of the Omnibus Budget Reconciliation Act of 1986, P.L. No. 99-509, requires hospitals to report claims for outpatient services using coding from the Healthcare Common Procedure Coding System (HCPCS). 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" requires the fiscal intermediary to maintain adequate internal controls over Medicare automatic data processing systems to preclude increased program costs and erroneous and/or delayed payments.

Beginning January 3, 2006, CMS required intermediaries to implement a Fiscal Intermediary Standard System edit to suspend potentially excessive Medicare payments for prepayment review. This edit suspends high-dollar outpatient claims and requires intermediaries to determine the legitimacy of the claims.

INAPPROPRIATE HIGH-DOLLAR PAYMENT

For one claim, the provider billed 440 units of Gamunex (HCPCS code J1561), a drug used for immune globulin intravenous therapy, for each of two dates of service. The provider should have billed 220 units for each of the dates of service, which was the number of units provided. It also billed HCPCS code J1561 for 220 units for a date for which the patient never received the drug. Pinnacle paid the provider $55,787 when it should have paid $34,061, an overpayment of $21,726.

CAUSES OF OVERPAYMENT

The provider reported that the number of units was inadvertently entered two times rather than one. In addition, the provider's review process was not comprehensive enough to determine that medication was not administered on one of the dates of service originally claimed.

Further, at the time the claim was processed, Pinnacle's procedures for determining the accuracy of the claims that were suspended by the high-dollar edit were not adequate. When a claim was suspended, Pinnacle contacted the provider and required it to verify whether the number of units and charges billed on the claim were correct. If the provider determined that the units and charges claimed were correct, Pinnacle instructed the provider to indicate that on the claim. Pinnacle did not request any medical documentation from the provider. However, beginning in August 2009, Pinnacle implemented a policy for claims with J-codes that were suspended due to the high-dollar edit. The new policy requires providers to submit medical records to Pinnacle for medical review and payment determination. Although Pinnacle implemented the prepayment edit and medical review policy, its procedures, at the time the claim was processed, were not

adequate because it relied on providers to self-review claims for accuracy and on beneficiaries to review their Explanation of Medicare Benefits and disclose any inappropriate payments.[1]

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the $21,726 is refunded, and

- use the results of this audit in its ongoing provider education activities.

PINNACLE COMMENTS

In response to our draft report, Pinnacle reported that the entire $21,726 was recovered. Pinnacle's comments are included in their entirety as Appendix B.

[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.

APPENDIX

APPENDIX: PINNACLE COMMENTS

MEDICARE
Part A Intermediary
Part B Carrier

Regina H. Favors
President & CEO
Office 501-710-8036
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rfavors@pinnaclebsi.com

August 20, 2010

Ms. Patricia Wheeler
Regional Inspector General for Audit Services
Office of Inspector General
Office of Audit Services, Region VI
1100 Commerce Street, Room 632
Dallas, TX 75242

Dear Ms. Wheeler:

This is in response to your letter of July 19, 2010 regarding OIG Draft Audit Number A-06-10-00034. An adjustment was processed in December 2009 regarding the claim in question and the $21,726 was recovered from the provider on the remittance advice dated December 9, 2009.

Please feel free to call should you have questions or need additional assistance.

Sincerely,

Regina Favors

RHF:sm

cc: Michelle Richards