



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

December 12, 2011

TO: Marilyn Tavenner
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: /Gloria L. Jarmon/
Deputy Inspector General for Audit Services

SUBJECT: Review of Medicare Payments Exceeding Charges for Outpatient Services
Processed by Pinnacle in Jurisdiction 7 for the Period January 1, 2006, Through
June 30, 2009 (A-06-10-00046)

Attached, for your information, is an advance copy of our final report on Medicare payments exceeding charges for outpatient services processed by Pinnacle Business Solutions, Inc. (Pinnacle), in Jurisdiction 7. We will issue this report to Pinnacle within 5 business days.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact Brian P. Ritchie, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through email at Brian.Ritchie@oig.hhs.gov or Patricia Wheeler, Regional Inspector General for Audit Services, Region VI, at (214) 767-8414 or through email at Trish.Wheeler@oig.hhs.gov. Please refer to report number A-06-10-00046.

Attachment



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

December 19, 2011

Report Number: A-06-10-00046

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 and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by Pinnacle in Jurisdiction 7 for the Period January 1, 2006, Through June 30, 2009*. 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, the final 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-06-10-00046 in all correspondence.

Sincerely,

/Patricia Wheeler/
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, MO 64106

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE PAYMENTS
EXCEEDING CHARGES FOR OUTPATIENT
SERVICES PROCESSED BY PINNACLE
IN JURISDICTION 7
FOR THE PERIOD JANUARY 1, 2006,
THROUGH JUNE 30, 2009**



Daniel R. Levinson
Inspector General

December 2011
A-06-10-00046

Office of Inspector General

<http://oig.hhs.gov>

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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.

EXECUTIVE SUMMARY

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 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 Medicare contractors to process and pay Medicare claims submitted for outpatient services. The Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF) to process claims. The CWF can detect certain improper payments during prepayment validation.

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers 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 or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description. In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

During our audit period (January 2006 through June 2009), Pinnacle Business Solutions, Inc. (Pinnacle), processed approximately 32 million line items for outpatient services in Arkansas, of which 596 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000 and (2) 3 or more units of service. On claims from the same providers that submitted the 596 line items, we identified an additional 274 line items that had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$500 and (2) 3 or more units of service. (A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these criteria. Because the terms "payments" and "charges" generally are applied to claims, we will use "line payment amounts" and "line billed charges.")

OBJECTIVE

Our objective was to determine whether certain Medicare payments in excess of charges that Pinnacle made to providers for outpatient services were correct.

SUMMARY OF FINDINGS

Of the 870 selected line items for which Pinnacle made Medicare payments to providers for outpatient services during our audit period, 181 were correct. Providers refunded overpayments on 14 line items totaling \$167,617 before our fieldwork. The remaining 675 line items were incorrect and included overpayments totaling \$2,159,595 that the providers had not refunded by the beginning of our audit.

Of the 675 incorrect line items:

- Providers reported incorrect units of service on 365 line items, resulting in overpayments totaling \$1,385,800.
- Providers used HCPCS codes that did not reflect the procedures performed on 264 line items, resulting in overpayments totaling \$585,271.
- Providers did not provide the supporting documentation for 44 line items, resulting in overpayments totaling \$185,423.
- Providers billed for unallowable services on two line items, resulting in overpayments totaling \$3,101.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Pinnacle made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the \$2,159,595 in identified overpayments has been recovered,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In its comments on our draft report, Pinnacle concurred with our recommendations and said that all adjustments had been processed and collections completed.

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INTRODUCTION

BACKGROUND

Pursuant to Title XVIII of the Social Security Act, the Medicare program provides health insurance for people aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Part B of the Medicare program helps cover medically necessary services such as doctors' services, outpatient care, home health services, and other medical services. Part B also covers some preventive services.

Medicare Contractors

CMS contracts with Medicare contractors to, among other things, process and pay Medicare Part B claims submitted for outpatient services.¹ The Medicare contractors' responsibilities include determining reimbursement amounts, conducting reviews and audits, and safeguarding against fraud and abuse. Federal guidance provides that Medicare contractors must 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 Medicare contractors use the Fiscal Intermediary Standard System and CMS's Common Working File (CWF). The CWF can detect certain improper payments during prepayment validation.

Claims for Outpatient Services

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains details regarding each provided service (called a line item in this report). Providers 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 or, if the HCPCS code is associated with a drug, the number of billable units administered, as defined by the HCPCS code description.² In addition, providers should charge Medicare and other payers, such as private insurance companies, uniformly. However, Medicare uses an outpatient prospective payment system to pay certain outpatient providers. In this method of reimbursement, the Medicare payment is not based on the amount that the provider charges. Consequently, the billed charges (the prices that a provider sets for its services) generally do not affect the current Medicare prospective payment amounts. Billed charges generally exceed the amount that Medicare pays the provider. Therefore, a Medicare payment that significantly exceeds the billed charges is likely to be an overpayment.

¹ Section 911 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. No. 108-173, required CMS to transfer the functions of fiscal intermediaries and carriers to Medicare administrative contractors (MAC) between October 2005 and October 2011. Most, but not all, of the MACs are fully operational; for jurisdictions where the MACs are not fully operational, the fiscal intermediaries and carriers continue to process claims. In this report, the term "Medicare contractor" means the fiscal intermediary, carrier, or MAC, whichever is applicable.

² HCPCS codes are used throughout the health care industry to standardize coding for medical procedures.

Pinnacle Business Solutions, Inc.

During our audit period (January 2006 through June 2009), Pinnacle Business Solutions, Inc. (Pinnacle), was the Medicare contractor for Arkansas providers. Pinnacle processed approximately 32 million line items for outpatient services during this period. In October 2009, Pinnacle assumed the Louisiana and Mississippi workload from TriSpan Health Services, making Pinnacle the Medicare contractor for all three States in Jurisdiction 7: Arkansas, Louisiana, and Mississippi. In this report, we address only claims processed by Pinnacle for Arkansas providers. We addressed the claims processed by TriSpan Health Services for Louisiana and Mississippi providers in a separate report to Pinnacle, *Review of Medicare Payments Exceeding Charges for Outpatient Services Processed by TriSpan but Transitioned to Pinnacle in Jurisdiction 7 for the Period January 1, 2006, Through June 30, 2009* (A-06-10-00048).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether certain Medicare payments in excess of charges that Pinnacle made to providers for outpatient services were correct.

Scope

Of the approximately 32 million line items for outpatient services that Pinnacle processed during the period January 2006 through June 2009, 596 line items had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000 and (2) 3 or more units of service.³ On claims from the same providers, we identified an additional 274 line items that had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$500 and (2) 3 or more units of service.

We limited our review of Pinnacle's internal controls to those that were applicable to the adjudication of the selected line items 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.

Our fieldwork included contacting Pinnacle in Little Rock, Arkansas, and the 25 providers that received the selected Medicare payments.

³A single Medicare claim from a provider typically includes more than one line item. In this audit, we did not review entire claims; rather, we reviewed specific line items within the claims that met these criteria. Because the terms "payments" and "charges" are generally applied to claims, we will use "line payment amounts" and "line billed charges."

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify outpatient line items processed by Pinnacle for providers that billed line items with (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$1,000 and (2) 3 or more units of service;
- identified additional line items from these same providers that had (1) a Medicare line payment amount that exceeded the line billed charge amount by at least \$500 and (2) 3 or more units of service;
- identified 870 line items totaling approximately \$3.7 million that Medicare paid to 25 providers;⁴
- contacted the 25 providers that received Medicare payments associated with the selected line items to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;
- reviewed documentation that the providers furnished to verify whether each selected line item was billed correctly;
- coordinated the calculation of overpayments with Pinnacle; and
- discussed the results of our review with Pinnacle officials on February 22, 2011.

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 findings and conclusions based on our audit objective.

FINDINGS AND RECOMMENDATIONS

Of the 870 selected line items for which Pinnacle made Medicare payments to providers for outpatient services during our audit period, 181 were correct. Providers refunded overpayments on 14 line items totaling \$167,617 before our fieldwork. The remaining 675 line items were incorrect and included overpayments totaling \$2,159,595 that the providers had not refunded by the beginning of our audit.

⁴ We did not review 14 of the 870 selected line items because providers refunded overpayments before our fieldwork and because payments no longer exceeded charges by at least \$500 for those line items.

Of the 675 incorrect line items:

- Providers reported incorrect units of service on 365 line items, resulting in overpayments totaling \$1,385,800.
- Providers used HCPCS codes that did not reflect the procedures performed on 264 line items, resulting in overpayments totaling \$585,271.
- Providers did not provide the supporting documentation for 44 line items, resulting in overpayments totaling \$185,423.
- Providers billed for unallowable services on two line items, resulting in overpayments totaling \$3,101.

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Pinnacle made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place during our audit period to prevent or detect the overpayments.

FEDERAL REQUIREMENTS

Section 1833(e) of the Social Security Act states: “No payment shall be made to any provider of services ... unless there has been furnished such information as may be necessary in order to determine the amounts due such provider ... for the period with respect to which the amounts are being paid”

CMS’s *Medicare Claims Processing Manual*, Pub. No. 100-04 (the Manual), chapter 23, section 20.3, states: “providers must use HCPCS codes ... for most outpatient services.” Chapter 25, section 75.5, of the Manual states: “when HCPCS codes are required for services, the units are equal to the number of times the procedure/service being reported was performed.”⁵ If the provider is billing for a drug, according to chapter 17, section 70, of the Manual, “[w]here HCPCS is required, units are entered in multiples of the units shown in the HCPCS narrative description. For example, if the description for the code is 50 mg, and 200 mg are provided, units are shown as 4”

Chapter 1, section 80.3.2.2, of the Manual states: “In order to be processed correctly and promptly, a bill must be completed accurately.”

⁵ Prior to CMS Transmittal 1254, Change Request 5593, dated May 25, 2007, and effective June 11, 2007, this provision was located at chapter 25, section 60.5, of the Manual.

OVERPAYMENTS FOR SELECTED LINE ITEMS

Incorrect Number of Units of Service

Providers reported an incorrect number of units of service on 365 line items, resulting in overpayments totaling \$1,385,800. The following examples illustrate the incorrect number of units of service:

- One provider billed Medicare for an incorrect number of units of service on 24 line items. Rather than billing 1 service unit, the provider billed 12 service units. As a result of these errors, Pinnacle paid the provider \$284,208 when it should have paid \$20,377, an overpayment of \$263,831.
- Another provider billed Medicare for an incorrect number of units of service on 85 line items. Rather than billing between 5 and 60 service units, the provider billed between 100 and 901 service units. These errors occurred because the provider's chargemaster⁶ was incorrect. As a result of these errors, Pinnacle paid the provider \$245,041 when it should have paid \$15,811, an overpayment of \$229,230.

Incorrect Healthcare Common Procedure Coding System Codes

Providers used HCPCS codes that did not reflect the procedures performed on 264 line items, resulting in overpayments totaling \$585,271.

For example, 1 provider billed Medicare for 219 line items of a chemotherapy drug with an HCPCS code for a 3.75-milligram (mg) dose that is used for the treatment of uterine cancer rather than for the HCPCS code with the correct dosage (7.5 mg) that is used for the treatment of prostate cancer. As a result of these errors, Pinnacle paid the provider \$464,495 when it should have paid \$118,315, an overpayment of \$346,180.

Unsupported Services

Seven providers billed Medicare for 44 line items for which the providers did not provide supporting documentation. As a result of these errors, Pinnacle paid the providers \$185,423 when it should have paid \$0, an overpayment of \$185,423.

Services Not Allowable for Medicare Reimbursement

Two providers incorrectly billed Medicare for two line items for which the services rendered were not allowable for Medicare reimbursement, resulting in overpayments totaling \$3,101. For example, one provider billed for alveoplasty (surgical preparation of the alveolar ridges for the reception of dentures), which is not a covered procedure according to the *Medicare Benefit Policy Manual*, Pub. No. 100-02, chapter 15, section 150. As a result, Pinnacle paid the provider \$1,454 when it should have paid \$0, an overpayment of \$1,454.

⁶ A provider's chargemaster contains data on every chargeable item or procedure that the provider offers.

CAUSES OF INCORRECT MEDICARE PAYMENTS

The providers attributed the incorrect payments to clerical errors or to billing systems that could not prevent or detect the incorrect billing of units of service and other types of billing errors. Pinnacle made these incorrect payments because neither the Fiscal Intermediary Standard System nor the CWF had sufficient edits in place to prevent or detect the overpayments. In effect, CMS relied on providers to notify the Medicare contractors of incorrect payments and on beneficiaries to review their *Medicare Summary Notice* and disclose any overpayments.⁷

On January 3, 2006, CMS required Medicare contractors to implement a Fiscal Intermediary Standard System edit to suspend potentially incorrect Medicare payments for prepayment review. As implemented, this edit suspends payments exceeding established thresholds and requires Medicare contractors to determine the legitimacy of the claims. However, the edit did not detect the errors that we found because it considers only the amount of the payment, suspends only payments that exceed the threshold, and does not flag payments that exceed charges.

RECOMMENDATIONS

We recommend that Pinnacle:

- ensure that the \$2,159,595 in identified overpayments has been recovered,
- implement system edits that identify line item payments that exceed billed charges by a prescribed amount, and
- use the results of this audit in its provider education activities.

PINNACLE BUSINESS SOLUTIONS, INC., COMMENTS

In its comments on our draft report, Pinnacle concurred with our recommendations and said that all adjustments had been processed and collections completed.

OTHER MATTER

During our review, we identified additional line items for which providers had received Medicare reimbursement for services that were on claims associated with unallowable dental services. These payments were not within the scope of our audit because, in each case, the Medicare payment did not exceed the billed charges for the line item, or the line items had fewer than three units of service. For example, the providers billed for a dental surgery procedure and for anesthesia, which were not allowable for Medicare reimbursement. Pinnacle paid the providers \$2,162 when it should have paid \$0, an overpayment of \$2,162. Pinnacle recovered the overpayments after we brought the matter to its attention.

⁷ The Medicare contractor sends a *Medicare Summary Notice*—an explanation of benefits—to the beneficiary after the provider files a claim for services. The notice explains the services billed, the approved amount, the Medicare payment, and the amount due from the beneficiary.

APPENDIX

APPENDIX: PINNACLE BUSINESS SOLUTIONS INC., COMMENTS



MEDICARE
Part A Intermediary
Part B Carrier

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October 19, 2011

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

Dear Ms. Wheeler:

This is in response to your letter of September 19, 2011 regarding OIG Draft Audit Number A-06-10-00046. We concur with the recommendations. All adjustments have been processed and collections completed.

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

Sincerely,

A handwritten signature in cursive script that reads "Regina Favors".

RHF:rc

cc: Michelle Richards