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

March 6, 2003

Mr. Michael J. Daly
President
Baystate Health System
759 Chestnut Street
Springfield, Massachusetts 01199

Dear Mr. Daly:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' (OAS) report entitled, "Review of Outlier Payments Made to the Baystate Medical Center Under the Outpatient Prospective Payment System." A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action 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.

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), OIG, OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5)

To facilitate identification, please refer to Common Identification Number A-01-02-00528 in all correspondence relating to this report.

Sincerely yours,

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Mr. Joseph Tilghman
Regional Administrator, Region VII
Centers for Medicare and Medicaid Services
Richard Bolling Federal Building
601 East 12 Street, Room 235
Kansas City, Missouri 64106-2808

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF OUTLIER PAYMENTS MADE TO THE BAYSTATE MEDICAL CENTER UNDER THE OUTPATIENT PROSPECTIVE PAYMENT SYSTEM FOR THE PERIOD AUGUST 1, 2000 THROUGH JUNE 30, 2001

JANET REHNQUIST
Inspector General

March 2003
A-01-02-00528

Office of Inspector General

http://oig.hhs.gov

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The OIG's Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout the department.

Office of Evaluation and Inspections

The OIG's Office of Evaluation and Inspections (OEI) conducts short-term management and program evaluations (called inspections) that focus on issues of concern to the department, the Congress, and the public. The findings and recommendations contained in the inspections reports generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs.

Office of Investigations

The OIG's Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties. The OI also oversees state Medicaid fraud control units, which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops model compliance plans, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

EXECUTIVE SUMMARY

BACKGROUND

The Balanced Budget Act (BBA) of 1997 mandated the implementation of a Medicare prospective payment system for hospital outpatient services. As such, the Centers for Medicare and Medicaid Services (CMS) created the outpatient prospective payment system (OPPS). With some exceptions, payment for services under OPPS is calculated based on grouping services into ambulatory payment classification (APC) groups. Services within an APC are clinically similar and require similar resources. In this respect, some services such as anesthesia, supplies, certain drugs, and use of recovery and observation rooms are packaged in APCs and not paid separately. The BBA also allowed for the establishment of outlier adjustments, in a budget neutral manner, to ensure "equitable payments." The OPPS became effective for services provided on or after August 1, 2000.

OBJECTIVE

The objective of our review was to determine whether outpatient claims with outlier payments were billed in accordance with Medicare laws and regulations.

SUMMARY OF FINDINGS

For the period August 1, 2000 through June 30, 2001, the Baystate Medical Center (Hospital) submitted 2,562 outpatient claims with outlier payments totaling $834,853. We reviewed a sample of 38 such claims, totaling $145,736, and found that 37 claims were incorrectly billed by the Hospital. The billing errors include both overpayments and underpayments resulting in a net Medicare overpayment to the Hospital of $7,939. Claims billed incorrectly included:

- 32 claims for which the Hospital did not apply an appropriate APC code,
- 3 claims for which the Hospital did not apply the correct units in accordance with CMS instructions, and
- 2 claims which included clerical errors.

RECOMMENDATION

We recommend that the Hospital:

- Strengthen its policies and procedures with regard to billing for outpatient services under OPPS, and
- Initiate adjustments with Mutual of Omaha, the Medicare Fiscal Intermediary (FI), for the $7,939 in overpayments identified through this audit.

The Hospital, in its February 12, 2003 response to our draft report (see APPENDIX), agreed with our audit findings and indicated the corrective actions it has taken. The Hospital also indicated that it has rebilled the FI to correct the $7,939 in overpayments identified in our report.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	1
OBJECTIVES, SCOPE AND METHODOLOGY	1
FINDINGS AND RECOMMENDATIONS	2
MEDICATIONS BILLED WITHOUT AN APC CODE	2
NUMBER OF UNITS BILLED	3
CLERICAL ERRORS	3
CONCLUSION	3
RECOMMENDATIONS	3
AUDITEE RESPONSE	4
APPENDIX	
BAYSTATE MEDICAL CENTER RESPONSE TO DRAFT REPORT	

INTRODUCTION

BACKGROUND

The Balanced Budget Act (BBA) of 1997 mandated that the Centers for Medicare and Medicaid Services (CMS) implement a Medicare prospective payment system for hospital outpatient services. As such, CMS implemented the outpatient prospective payment system (OPPS). With the exception of certain services, payment for services under OPPS is calculated based on grouping services into ambulatory payment classification (APC) groups. Services within an APC are clinically similar and require similar resources. In this respect, some services such as anesthesia, supplies, certain drugs, and use of recovery and observation rooms are packaged in APCs and not paid separately. The BBA also allowed for establishment of outlier adjustments, in a budget neutral manner, to ensure "equitable payments."

The Balanced Budget Refinement Act of 1999 further delineated the requirements for outlier payments for hospitals to cover some of the additional cost of providing care that exceed thresholds established by the Secretary. The payments in total can be no more than 2.5 percent of total program payments for outpatient hospital services for each year before 2004. Outlier payments are determined by: (1) calculating the costs related to the OPPS services on the claim by multiplying the total charges for covered OPPS services by an outpatient cost-to-charge ratio; (2) determining whether these costs exceed 2.5 times the OPPS payments; and (3) if costs exceed 2.5 times the OPPS payments, the outlier payment is calculated as 75 percent of the amount by which the costs exceed the OPPS payments. The OPPS became effective for services provided on or after August 1, 2000.

The Baystate Medical Center (Hospital) is an acute care hospital located in Springfield, Massachusetts. The Hospital had 2,562 outpatient claims with outlier payments totaling $834,853 for services rendered during the period August 1, 2000 through June 30, 2001.

OBJECTIVE, SCOPE AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether outpatient claims with outlier payments were billed in accordance with Medicare laws and regulations. Our review included OPPS outlier payments to the Hospital for services rendered during the period August 1, 2000 through June 30, 2001.

To accomplish our objective, we:

- Used CMS's National Claims History file to identify 2,562 outpatient claims with outlier payments totaling $834,853 made to the Hospital for services rendered during the period August 1, 2000 through June 30, 2001.

- Analyzed the Hospital's outlier claims for our audit period to identify high-risk claims, such as those where the outlier payment represented a significant percentage of the total

payment of the claim. On this basis, we selected a judgmental sample of 38 claims with outlier payments totaling $145,736 for review.

- Obtained supporting billing records for the sampled claims from the Hospital and independently re-priced these claims.

We limited our review of the internal control structure to those controls concerning the accumulation of charges, the creation of outpatient bills, and submission of claims to the Medicare Fiscal Intermediary (FI). The objective of our review did not require an understanding or assessment of the complete internal control structure at the Hospital.

We conducted our audit during the period of August 2002 through November 2002 at the Hospital in Springfield, Massachusetts and at our Hartford, Connecticut field office.

The Hospital's response to our draft report is appended to this report (see APPENDIX).

FINDINGS AND RECOMMENDATIONS

We found that the Hospital needs to strengthen its policies and procedures for billing the Medicare program for services covered under the OPPS. We reviewed a judgmentally selected sample of 38 outpatient hospital claims with outlier payments totaling $145,736. Most of these claims with high outlier payments were associated with the administration of oncology medications. Based on our review, we found that 37 of the 38 claims were incorrectly billed by the Hospital. The billing errors included both overpayments and underpayments resulting in a net Medicare overpayment to the Hospital of $7,939. The billing errors included:

- 32 claims for which the Hospital did not apply an appropriate APC code,

- 3 claims for which the Hospital did not apply the correct units in accordance with CMS instructions, and

- 2 claims which included clerical errors.

The results of our review are discussed in detail below.

MEDICATIONS BILLED WITHOUT AN APC CODE

Under OPPS, many medications have individually assigned APCs which identify payments based on specific dosage units. For example, the drug Epogen is assigned an APC code of 733. Reimbursement for Epogen is based on a dosage of 1,000 units. Drugs which do not have an assigned APC are grouped on the Medicare claim form under revenue center code (RCC) 250 – Pharmacy. While no direct APC payment is derived from drugs grouped under this RCC, significantly high charges can trigger an outlier payment. We found that for 32 claims in our sample, the Hospital incorrectly charged APC-coded drugs under RCC 250 instead of identifying them for separate payment. Oncology related medications such as Epogen, Sandostatin, Ondansetron and Aredia were commonly billed in this manner.

We re-priced these claims using the appropriate APC codes and billable units and found that the Hospital received net overpayments of $1,473 for these 32 incorrectly billed claims.

NUMBER OF UNITS BILLED

To determine OPPS payments, administered doses must be converted to billable units and APC payment rates are multiplied by the number of billable units. For 3 out of the 38 claims we reviewed, the Hospital used correct APC codes but did not determine the correct number of billable units. Such billing generates small OPPS payments but triggers large outlier payments. As an example, the Hospital administered 42 milligrams of the drug Cladribine for which it correctly billed under the 858 APC code. Under this APC code, 1 milligram comprises a billable unit. While the Hospital should have billed for 42 units, the Hospital instead billed for only 3 units. This effectively triggered an excessive outlier payment.

We re-priced the 3 claims in question and determined that the Hospital received overpayments of $2,337.

CLERICAL ERRORS

In accordance with 42 Code of Federal Regulations Section 482.24(c), a provider is required to maintain medical records that contain sufficient documentation to justify admission, services furnished, diagnoses, treatment performed and continued care. We identified two claims for which the units identified in the supporting billing and medical records did not match the units on the Medicare claim form. The Hospital attributed these to clerical errors.

We re-priced the two claims in question and determined that the Hospital received overpayments of $4,129.

CONCLUSION

In summary, we believe that the Hospital needs to strengthen its controls for billing Medicare for certain medications under OPPS. Of the 38 claims selected for review, we found that 37 of these claims were incorrectly priced resulting in both underpayments and overpayments to the Medicare program. However, the effect of these errors was minimal, in that it resulted in a net overpayment to the Hospital of $7,939.

RECOMMENDATIONS

We recommend that the Hospital:

- Strengthen its policies and procedures with regard to billing for outpatient services under OPPS, and

- Initiate adjustments with Mutual of Omaha, the Medicare FI, to reimburse Medicare for the $7,939 in overpayments identified through this audit.

AUDITEE RESPONSE

In its February 12, 2003 response to our draft report (see APPENDIX), the Hospital agreed with our findings and recommendations. The Hospital indicated in its response that it has undergone a focused review of its pharmacy and supply codings and has made corrections to its Charge Description Master. The Hospital stated that it has developed policies and procedures involving updates to its Charge Description Master including coding updates for drugs. The Hospital stated that it has also rebilled the FI to correct the claims identified as errors in our report.

A P P E N D I X

Baystate
Medical Center
A Member of Baystate Health System
Springfield, Massachusetts 01199
413-794-0000

February 12, 2003

Mr. Michael J. Armstrong
Regional Inspector General for Audit Services
Office of Audit Services, Region I
John F. Kennedy Federal Building
Boston, MA 02203

Re: Common Identification Number: A-01-02-00528

Dear Mr. Armstrong:

We have reviewed the draft of the report providing Baystate Medical Center (the "Medical Center") with the results of your audit entitled "Review of Outlier Payments made to the Baystate Medical Center Under the Outpatient Prospective Payment System." The report provided background on the Medicare outpatient prospective payment system and outlier adjustments, the objective, scope, and methodology of your review, and your findings and recommendations.

Based on our review of the draft report, the Medical Center accepts and generally agrees with the findings disclosed therein. We feel that it is important, however, to put the Office of Inspector General (the "OIG") findings in context and to highlight efforts that the Medical Center has made to comply with the complexities in the implementation of the Medicare outpatient prospective payment system, particularly as it relates to billing for outpatient oncology drugs.

1) As indicated in your report the OIG analyzed the Medical Center's outlier claims to identify "high risk" claims which formed the basis for the judgmental sample selected for review.
2) All of the accounts identified to be in error involved billing for outpatient drugs, primarily Oncology medications requiring the use of Revenue Code 636 – Drugs requiring detailed codes (32 of 38 claims).
3) As indicated in your report, the billing errors included both overpayments and underpayments resulting in the net overpayment to the Medical Center of $7,939.00. There were 13 of the 38 claims which resulted in underpayments.

The Medical Center has made significant improvements which respond to the recommendations in your report.

1) Over the past two years the Medical Center has performed extensive reviews of our Charge Description Master since the period under review of this audit. In particular, the pharmacy and supply coding had a focused review completed and corrections to our Charge Description Master were made prior to your recommendations to us.
2) The Medical Center has developed policies and procedures involving updates to its Charge Description Master including coding updates for drugs.
3) The Medical Center has rebilled to Mutual of Omaha the claims identified to be in error in your report.

Baystate Medical Center is committed to maintaining compliance with all Medicare rules and regulations related to outlier payments. If I can be of any further assistance, please do not hesitate to contact me at 413-794-2578.

Sincerely,

Peter Lyons

Peter Lyons
Vice-President Finance, Support Services

ACKNOWLEDGMENTS

This report was prepared under the direction of Michael Armstrong, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Robert Champagne, *Audit Manager*
Gregory Pasko, *Senior Auditor*
John Bergeron, *Auditor*
Erica Law, *Auditor*

For information or copies of this report, please contact the Office of Inspector General's Public Affairs office at (202) 619-1343.