DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES, REGION IX
90 - 7TH STREET, SUITE 3-650
SAN FRANCISCO, CA 94103

April 24, 2012

Report Number: A-09-11-02069

Ms. June Collison
President
Community Hospital of San Bernardino
1805 Medical Center Drive
San Bernardino, CA 92411

Dear Ms. Collison:

Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled *Review of Medicare Outpatient Billing for Selected Drugs at Community Hospital of San Bernardino.* 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 contact Kimberly Kennedy, Senior Auditor, at (415) 437-8360 or through email at Kimberly.Kennedy@oig.hhs.gov, or contact Alice Norwood, Audit Manager, at (415) 437-8360 or through email at Alice.Norwood@oig.hhs.gov. Please refer to report number A-09-11-02069 in all correspondence.

Sincerely,

/Lori A. Ahlstrand/
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 OUTPATIENT BILLING FOR SELECTED DRUGS AT COMMUNITY HOSPITAL OF SAN BERNARDINO

Daniel R. Levinson
Inspector General

April 2012
A-09-11-02069

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:

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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 administers the program.

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail 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 units administered.

Community Hospital of San Bernardino (Community) is an acute-care hospital located in San Bernardino, California. Based on data analysis, we reviewed $87,124 in Medicare payments to Community for 48 line items for injections of selected drugs that Community billed to Medicare during our audit period (March 1, 2008, through April 30, 2011). These line items consisted of injections for epoetin alfa, rituximab, and adenosine.

OBJECTIVE

Our objective was to determine whether Community billed Medicare for injections of selected drugs in accordance with Federal requirements.

SUMMARY OF FINDINGS

For all of the 48 line items reviewed, Community did not bill Medicare in accordance with Federal requirements. Specifically, for all 48 line items, Community billed the incorrect number of units of service. As a result, Community received overpayments totaling $72,894. Community attributed the overpayments to its billing system and clerical errors.

RECOMMENDATIONS

We recommend that Community:

- refund to the Medicare administrative contractor $72,894 in identified overpayments and
- ensure compliance with Medicare billing requirements.

COMMUNITY HOSPITAL OF SAN BERNARDINO COMMENTS

In written comments on our draft report, Community agreed with our findings and provided information on actions that it had taken to address our recommendations. Community'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 aged 65 and over and those who are disabled or have permanent kidney disease. The Centers for Medicare & Medicaid Services (CMS) administers the program.

Medicare Requirements for Outpatient Claims

Medicare guidance requires providers to submit accurate claims for outpatient services. Each submitted Medicare claim contains detail 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 units administered.[1]

Selected Drugs

The drugs we reviewed in this audit were epoetin alfa, rituximab, and adenosine.

Epoetin Alfa

Epoetin alfa is an injectable drug used to treat anemia. Medicare requires providers to bill one service unit for each 1,000 units of epoetin alfa. The HCPCS code for this drug is J0885 and is described as "Injection, epoetin alfa, (for non-esrd [end-stage renal disease] use), 1000 units."

Rituximab

Rituximab is an injectable drug used to treat non-Hodgkin's lymphoma. Medicare requires providers to bill one service unit for each 100-milligram injection of rituximab. The HCPCS code for this drug is J9310 and is described as "Injection, rituximab, 100 [milligrams]."

Adenosine

Adenosine is an injectable drug used to treat supraventricular tachycardia. Medicare requires providers to bill one service unit for each 30-milligram injection of adenosine. The HCPCS code for this drug is J0152 and is described as "Injection, adenosine for diagnostic use, 30 [milligrams]."

[1] HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.

Community Hospital of San Bernardino

Community Hospital of San Bernardino (Community) is an acute-care hospital located in San Bernardino, California. Community's claims are processed and paid by Palmetto GBA, LLC, the Medicare administrative contractor.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Community billed Medicare for injections of selected drugs in accordance with Federal requirements.

Scope

We reviewed $87,124 in Medicare payments to Community for 48 line items that we selected as potentially at risk for billing errors during our audit period (March 1, 2008, through April 30, 2011). These line items consisted of:

- 45 line items for epoetin alfa totaling $68,676,
- 2 line items for rituximab totaling $17,785, and
- 1 line item for adenosine totaling $663.

We identified these payments through data analysis.

We did not review Community's internal controls applicable to the 48 line items because our objective did not require an understanding of controls over the submission 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 for our audit period, but we did not assess the completeness of the file.

Our fieldwork included contacting Community, located in San Bernardino, California.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- used CMS's National Claims History file to identify paid Medicare claims for epoetin alfa, rituximab, and adenosine;
- used computer matching, data mining, and analysis techniques to identify line items potentially at risk for noncompliance with Medicare billing requirements;

- identified 48 line items totaling $87,124 that Medicare paid to Community;

- contacted Community to determine whether the information conveyed in the selected line items was correct and, if not, why the information was incorrect;

- reviewed documentation that Community furnished to verify whether each selected line item was billed correctly;

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our review with Community.

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

For all of the 48 line items reviewed, Community did not bill Medicare in accordance with Federal requirements. Specifically, for all 48 line items, Community billed the incorrect number of units of service. As a result, Community received overpayments totaling $72,894. Community attributed the overpayments to its billing system and clerical errors.

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 HCPCS codes.

Section 1833(e) of the 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 4, section 20.4, states: "The definition of service units … is the number of times the service or procedure being reported was performed."

The Manual, chapter 17, section 90.2.A, states: "It is … of great importance that hospitals billing for [drugs] make certain that the reported units of service of the reported HCPCS code are consistent with the quantity of a drug … that was used in the care of the patient." 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."

INCORRECT BILLING

For all 48 line items reviewed, Community billed Medicare for the incorrect number of units of service:

- For the 45 line items for epoetin alfa, Community billed the incorrect number of units of service. Rather than billing from 16 to 40 service units, Community billed from 120 to 600 service units, resulting in overpayments totaling $62,556.

- For the 2 line items for rituximab, Community billed the incorrect number of units of service. Rather than billing 8 and 10 service units, Community billed 16 and 20 service units, respectively, resulting in overpayments totaling $9,786.

- For the one line item for adenosine, Community billed the incorrect number of units of service. Rather than billing 2 service units, Community billed 12 service units, resulting in an overpayment of $552.

In total, Community received overpayments of $72,894. Community attributed the overpayments to its billing system and clerical errors.

RECOMMENDATIONS

We recommend that Community:

- refund to the Medicare administrative contractor $72,894 in identified overpayments and

- ensure compliance with Medicare billing requirements.

COMMUNITY HOSPITAL OF SAN BERNARDINO COMMENTS

In written comments on our draft report, Community agreed with our findings and provided information on actions that it had taken to address our recommendations. Community's comments are included in their entirety as the Appendix.

APPENDIX

APPENDIX: COMMUNITY HOSPITAL OF SAN BERNARDINO COMMENTS

Community Hospital
of San Bernardino
A Dignity Health Member

March 12, 2012

U. S. Department of Health and Human Services
Office of Inspector General

Report Number: A-09-11-02069 / Community Hospital of San Bernardino

Objective: OIG conducted a review of Medicare payments for outpatient services to determine whether Community Hospital of San Bernardino (CHSB) billed Medicare for selected injectable drugs in accordance with Medicare requirements.

CHSB has reviewed the OIG Draft report and agree with the findings that both a system error and clerical error occurred. CHSB created a team to review the accounts selected by the OIG, the team consisted of our Government Billing Manager, Nurse Auditor, Medicare Biller, Pharmacy Analyst, and Pharmacy Director.

The following summarizes the review and corrective action:

- During the course of this audit it was discovered that the multiplier calculation in the MediTech System was incorrect, causing a mathematical charging error in the number of units being charged. Secondly, the clerical error was not recognizing/questioning the excessive number of units on the UB-04. Education and review has been provided to the Medicare billing team along with providing an example UB04 billing template for drug classification from the Medicare website.
- The multiplier calculation was corrected and tested for its accuracy.
- Charges associated with the Audit were recalculated with the correct multiplier in place and corrected claims were then submitted to Medicare
- The submission of the corrected claims created in a take back of the original Medicare payment and a re-payment based on the corrected number of units. This process resulted in a re-payment (refund) to Medicare of $72,894.00. The repayment is complete.
- In coordination with the Pharmacy Department and the Nurse Auditor, a report has been created in order to monitor the number of units coming from MediTech to our billing system.
- A monthly review is conducted by the Nurse Auditor; any discrepancies identified by the Nurse Auditor will be reviewed with the Pharmacy Analysts and corrected.

Lyn Miner
Director of Business Services
Community Hospital of San Bernardino